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CONTROLLING ACUTE RESPIRATORY INFECTIONS: STRATEGIES FOR THE 1990s

SUMMARY

The present report has been prepared in response to Executive Board decision 1990/20 (E/ICEF/1990/13). It provides the latest information on the magnitude of acute respiratory infections (ARI), reviews the status of UNICEF support to national ARI efforts and analyses lessons learned to date. It outlines basic control strategies and makes recommendations for action in the 1990s.

ARI remains a principal killer of infants and children, up to 4.3 million per year, accounting for one third of all deaths in that age-group. The World Summit for Children, held on 30 September 1990, called for a one third reduction in ARI mortality by the year 2000, which will also contribute significantly to other principal Summit goals: reducing infant and child mortality and reducing severe and moderate malnutrition. The present report reviews and further endorses the basic strategy of standard case management, immunization and preventive measures to control ARI.

A global consensus on the control of ARI was reached at the International Consultation on Control of Acute Respiratory Infections held in December 1991. It is critical that community-level health workers and providers be empowered to diagnose and provide front-line treatment and to use antibiotics (after training and under close supervision). Essential and affordable drugs must be made available when and where needed. In addition, effective means of communication to inform and educate people will be necessary if significant breakthroughs are to be made in the implementation of national policies in the control of ARI.

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INTRODUCTION

1. In 1990, a policy review on acute respiratory infections (ARI) was presented to the Executive Board (E/ICEF/1990/L.7). The policy review provided an overview of ARI, described the UNICEF experience in the control of ARI and made a series of recommendations for future action. The Executive Board welcomed the policy review and requested that a strategy paper on the subject be prepared for the 1992 session (E/ICEF/1990/13, decision 1990/20). In response to that request, the present report provides the latest information on the magnitude of the ARI problem, reviews the status of UNICEF support to national ARI efforts, analyses lessons learned to date and, on the basis of the experience, outlines basic control strategies and recommendations for action for the 1990s.

2. Acute respiratory infections are among the most common diseases in children the world over. On average, children under five years of age suffer five to nine episodes of ARI if they live in urban areas and from three to five episodes if they live in rural areas. This incidence is almost the same for children living in developed and developing countries, although with the higher level of interaction in developed countries the urban/rural differences are less marked. The vast majority of these infections are caused by common cold viruses and result in mild and isolated illness. None the less, ARI represents either the first or the second cause of visits to health services by young children world wide. In developing countries, between 20 to 60 per cent of all outpatient consultations with children are for ARI.

3. Furthermore, while the annual incidence of pneumonia, the most severe manifestation of ARI, is 3 to 4 per cent in children under five years of age in industrialized countries, it ranges from 10 to 20 per cent in developing countries, reaching levels as high as 80 per cent in populations with a high prevalence of risk factors such as malnutrition and low birth weight.

4. In 1990, there were approximately 11,800 ARI-related deaths per day among children under five years of age, resulting in an annual toll of about 4.3 million lives, or one third of all deaths in this age group. 1/ If the average incidence of pneumonia remains constant, and if the current fatality rate of 5 per cent continues, approximately 45 million children will die from ARI-related causes in the 1990s.

5. In 1990, the World Health Organization (WHO) estimated ARI as the largest single cause of mortality among young children. This is attributable in part to the progress made in reducing deaths from other causes such as immunizable diseases and diarrhoeal dehydration. It is also due to the lack of effective ARI control efforts throughout much of the developing world.

6. At least five aspects of ARI must be considered in developing effective control strategies:

(a) The vast majority of ARI deaths are caused by pneumonia, 2/ up to 80 per cent of which are bacterial and could be treated with antibiotics;

(b) ARI is not a single syndrome. Effective control programmes require the recognition and treatment of pneumonia as well as the distinction between pneumonia and less severe diseases;

(c) On average, about 20 per cent of ARI deaths are linked to measles or pertussis, which are preventable through immunization;

(d) Essential to the success of ARI control programmes are the appropriate use and availability of antibiotics at health facilities for use by trained health workers. While reducing the use of antibiotics for coughs and colds usually results in a net decrease in the amount of drugs required for ARI, ensuring sufficient and constant supplies throughout the health system remains a major challenge;

(e) Most pneumonia deaths occur at a very early age. Several community-based studies suggest that about one half of these deaths occur in the first six months of life. This age distribution of deaths has several programme implications.

7. In September 1990, the World Summit for Children called for a one-third reduction in ARI-related deaths, compared with 1990 levels, by the year 2000. Achieving that goal is a precondition to achieving broader infant and child mortality reduction goals endorsed by the Summit. It will also contribute to reducing malnutrition among young children, another key child health goal for the 1990s.

8. UNICEF is committed to achieving substantial reductions in ARI-related deaths during the next decade. Action will be taken on three levels: (a) efforts will be made to reduce ARI deaths directly through the promotion of correct case management and indirectly through immunization; (b) increased attention to other health interventions and to improving children's nutritional status will also help to reduce the incidence and severity of pneumonia; and (c) preventive measures will be pursued that address risk factors both in individual children (e.g., low birth weight, vitamin A deficiencies, bottle feeding) and in the environment (e.g., indoor air pollution, passive smoke, overcrowding and chilling caused by lack of heat or clothing).

9. In December 1991, WHO, the United Nations Development Programme (UNDP) and UNICEF co-sponsored the first International Consultation on Control of Acute Respiratory Infections (ICCARI). The objectives of the Consultation were to provide leaders from the health community with up-to-date information and exchange of experiences on ARI control, including case management and national programme implementation; to promote a global consensus on the feasibility of ARI mortality reduction and the actions needed; and to generate increased donor interest in ARI. Over 400 participants from 60 countries attended, including ministers of health, other high-ranking government

officials, paediatricians, representatives of international development agencies and others working on ARI control at the national level. In addition to clarifying basic elements of standard case management and strengthening a global consensus on strategies and approaches as outlined in the present report, ICCARI also increased the understanding of and commitment to ARI control at the highest political levels. Participants called for a second consultation in 1994 to review progress, exchange experience and plan for the second half of the decade.

10. During the past two years, close cooperation has continued with WHO. Joint meetings have been held to achieve consensus on basic control strategies, to develop evaluation indicators and to specify key elements of home management. UNICEF field offices are encouraging adaptation of WHO treatment guidelines and training materials at the country level and are supporting research and monitoring activities in conjunction with WHO. In most countries, UNICEF and WHO are coordinating their support for national ARI control programmes to ensure consistency of advice and avoid duplication of effort.

I. PROGRAMME EXPERIENCE

11. The 1990 policy review outlined a number of lessons learned about ARI control from the limited experience available at that time. During the past two years, UNICEF involvement in national ARI control efforts has expanded significantly, both confirming early impressions and deepening appreciation of the factors that contribute to success in this area. Highlights of recent experience are outlined below and regional trends are given in the annex.

A. Case management

12. Standard case management is the central control strategy promoted by UNICEF and WHO. It has three main elements:

(a) Early recognition of pneumonia by health workers who distinguish it from other ARI by looking for such signs as the inability to drink, rapid breathing and chest in-drawing;

(b) Prompt treatment at home with oral antibiotics for children who do not have a severe case of pneumonia;

(c) An initial dose of antibiotics and referral to hospital for children who have severe pneumonia.

13. During the past several years, a number of studies have tested the effectiveness of standard case management (e.g., in Bangladesh, India, Indonesia, Nepal, Pakistan, the Philippines and the United Republic of Tanzania). Without exception, they yielded dramatic reductions in both ARI-related mortality (between 25 and 67 per cent) and in overall mortality

(from 13 to 55 per cent). While implementing control programmes on a larger scale is more complicated, the studies demonstrate the potential impact of standard case management and provide models for many of the national programmes now under way.

14. The major constraints to implementing case management include the reluctance of doctors and other health workers to change long-standing practices (e.g., prescription of antibiotics for coughs and colds); the difficulty in convincing mothers that children without pneumonia do not need antibiotics; the reluctance in some countries to involve community health workers (CHWs) in locating cases of pneumonia and/or administering treatment; and the inability of many health systems to ensure adequate training for health workers and reliable supplies of antibiotics, two essential managerial activities of the case management strategy.

B. The role of effective national leadership

15. Experience suggests that strong national coordination is necessary for successful control efforts, especially during early stages of programme development. The form of this coordination varies considerably, from separate units within ministries of health to national steering committees that involve a broad range of technical personnel. Whatever the mechanism, key functions at the central level include the following:

(a) Policy development. Decisions must be taken on a number of policy issues such as functions as regards diagnosis and treatment at each level of the health delivery system, including CHWs; children who should be examined for possible pneumonia; key signs to identify pneumonia; criteria for referral to hospital of children with signs of pneumonia; antibiotics for standard treatment of pneumonia at home and at hospital; and communications messages for home care advice. National programmes are encouraged to seek broad-based consensus on these issues, involving national medical associations, influential clinicians and other groups and/or individuals whose support for the programme is critical to long-term sustainability;

(b) Plans of action. While implementation of control activities occurs primarily at district and local levels, national plans of action ensure consistency in policies and treatment, as well as rational expansion of the programme to all areas of the country. Thus, while continuing to integrate ARI control activities with other district-level services, national programmes must also address the need for continuity of activities among different regions. Comprehensive national plans of action are essential if the control of ARI is to make a significant impact nationally;

(c) Evaluation and monitoring. National coordinating mechanisms can play a key role in monitoring the progress of control efforts in achieving operational targets and, at reasonable intervals, determining their impact on child health and survival. WHO is in the process of developing instruments to facilitate this task, including attitude and practice surveys at health

facilities and in households. UNICEF support for the implementation of these instruments and for the formulation of realistic objectives at all levels will be essential;

(d) Coordination of external support. Experience to date underlines the importance of clear national guidance on where and how donor support is directed, especially when ARI control activities are funded by different sources in different areas of the country. Rational development and expansion of the programme requires consistency in technical policies and managerial procedures.

C. Phasing of ARI control programmes

16. In the 1990 policy review, UNICEF supported a phased approach to the implementation of ARI control activities. This involves an initial emphasis on establishing correct case management at first-level health facilities, followed by the involvement of community-based health providers and, finally, broad-based education about home care. While experience during the past two years has underlined the need for flexibility, it has also confirmed the wisdom of establishing services at referral facilities before moving ahead with the training of CHWs or providing messages about home care. Referral is a basic component of standard case management; without adequate back-up services at higher levels, CHWs will be unable to ensure proper care of children with severe pneumonia or very severe disease, thus undermining the credibility of the programme.

17. It is also imperative that if the programme is to be effective, community-level health care workers must be empowered, following training and with guidance and close supervision, to use antibiotics.

18. In countries in which ARI control programmes are also phased in geographically, i.e., in which implementation has begun in limited areas before "going-to-scale", the involvement of CHWs in those areas may precede the establishment of referral services in other areas of the country.

D. Logistical requirements of ARI control programmes

19. An adequate supply of drugs and the widespread availability of simple technologies to assist in the diagnosis and treatment of pneumonia will become increasingly important in the next few years.

20. First, standard case management requires regular, adequate supplies of appropriate antibiotics. At present, many national programmes either have inadequate supplies or depend almost entirely on external support for their purchase and distribution. Neither of these strategies lends itself to long-term sustainability. Alternative approaches must be developed, including greater reliance on community procurement and management of drug supplies,

cost-sharing, etc., along the principles of the Bamako Initiative, and local production of antibiotics (e.g., cotrimoxazole) where feasible.

21. Secondly, the provision of 30- to 60-second respiratory rate timers to health workers who handle pneumonia cases helps to ensure consistency in treatment and diagnosis. The ability of health workers to observe rapid breathing (rather than use a stethoscope) is, in fact, one of the key aspects of standard case management and the reason why diagnosis is possible at peripheral and community levels. WHO and UNICEF have collaborated in the development of a simple and inexpensive timer, which will be available through the UNICEF Supply Division in 1992.

22. Finally, WHO and UNICEF have collaborated on the development of a low-cost oxygen concentrator, which can function adequately in the adverse environmental conditions of developing countries such as high humidity, high temperature, dusty air and wide variations in the electricity voltage. The availability of sufficient amounts of oxygen for severe cases can reduce mortality from pneumonia by up to 50 per cent. While the new models developed are relatively inexpensive, most programmes will require external support to procure sufficient quantities for even the most advanced health facilities.

E. ARI communications

23. The 1990 policy review described the main goal of ARI communications as helping caretakers to obtain the right therapy (antibiotics), for the right children (with pneumonia), from a trained health worker, at the right time and for the right duration. Experience over the past two years has confirmed that view and has underlined the need to coordinate messages with available services. Caretakers taught to recognize signs of pneumonia and seek help must have access to trained providers. If not, the confusion that results may jeopardize the long-term effectiveness of control efforts.

24. Given the early stage of development of most control programmes, emphasis remains on improving interpersonal communication between health providers and caretakers. The results of ethnographic surveys and other operational research (e.g., in Bangladesh, Bolivia, the Gambia and Thailand) are being used to improve messages and materials in this regard. Once the control and support systems are built and in place, communication efforts will need to be strengthened in order to promote information and education on the control of ARI.

F. Training of health personnel

25. In 1990, WHO was in the process of developing a series of training materials for ARI control. The materials have now been adapted in several countries and considerable experience has been gained in this area. For the most part, this experience has underlined the importance of well-organized training, including hands-on practice in the counting of respiratory rates and

recognition of chest in-drawing, and clear distinctions between different categories of providers (e.g., those who diagnose and provide treatment and those who simply recognize clinical signs and advise on when to seek help). The need for regular and high-quality supervision has also become increasingly clear.

26. UNICEF support has been, and will continue to be, crucial to the scope and quality of these training efforts. Continued collaboration with ministries of health and WHO in the design, implementation and evaluation of national training strategies will be an area of priority concern in the 1990s.

G. Household management of ARI

27. Despite the need for correct and timely interaction with health providers, caretakers can play a key role in preventing deaths from pneumonia. An experts meeting on the household management of the control of diarrhoeal diseases (CDD) and ARI organized in April 1990 by UNICEF and WHO (in collaboration with the Johns Hopkins University (United States)), identified three actions for caretakers at the household level: recognizing signs of pneumonia or serious illness; seeking treatment quickly when these signs occur; and complying with the treatment instructions of trained health providers.

28. Experience to date, supported by the results of ethnographic research, confirms mothers' abilities to discern serious illness and their willingness to use whatever services are available. While there is often initial resistance to a reduced dose of prescription drugs (which are now widely over-prescribed for coughs and colds), mothers support standard case management when they have access to trained providers and affordable drugs, if instructions are clearly explained and if compliance with instructions improves the health of their children.

H. Operational research

29. The 1990 policy review described a special multi-country ARI project involving Bolivia, the Gambia and Thailand. During the past two years, with the continued technical assistance of the Johns Hopkins University, the focus of this effort has been on the development of operational research in key areas of programme implementation. In all three countries, ethnographic surveys have been completed which increase understanding of caretakers' attitudes and practices related to ARI. The results have been used to improve training efforts as well as to design materials for use in interpersonal communication between health workers and mothers.

30. Additionally, research has been done in all three countries, on the treatment for pneumonia offered by different levels of the health system: in Bolivia, the effectiveness of competency-based training for CHWs was analysed; in the Gambia, a functional analysis of the health system was completed; and

in Thailand, a comparison was made of different training strategies for village health workers (VHWs). In each case, results are being used to improve programmes and develop research protocols for use in other countries.

31. As indicated in the review of UNICEF support to ARI control efforts, many countries are either planning or are already involved in operational research in a wide variety of areas. UNICEF and WHO are requested increasingly to assist countries in the design and implementation of these efforts. In doing so, they can also help national programmes balance research needs against the implementation of control activities, e.g., training, assuring adequate drug supplies, supervision, communication, monitoring and evaluation.

I. Prevention of pneumonia

32. During the past two years, efforts to identify key risk factors for pneumonia have continued. Supported by WHO and UNICEF, the London School of Hygiene and Tropical Medicine is conducting an intensive review of risk factors for pneumonia, with a view towards assessing their relationship to, and relative importance in, causing the disease among young children. The results of this study will be discussed during 1992, followed by further research on interventions to reduce these risks.

33. At present, immunization remains the key strategy for preventing pneumonia. About one in five pneumonia deaths is linked to measles and pertussis since pneumonia often develops as a complication of these two conditions. A study in India, for instance, showed that children who recovered from measles had a sixfold increase in acute lower respiratory infections during the following six months. None the less, the impact of immunization is not adequate for total prevention. Even if all children were immunized against measles and pertussis, the number of pneumonia deaths would be reduced by no more than 20 per cent. Furthermore, measles vaccinations given at nine months of age cannot influence the 50 per cent of pneumonia deaths occurring in the first six months of life. Fortunately, prospects for an effective pneumonia vaccine look promising, as research continues as part of both the WHO vaccine development programme and the inter-agency Children's Vaccine Initiative.

34. Improving the nutritional status of young children is the second major preventive strategy. Two of the most important risk factors for pneumonia are low birth weight and malnutrition. Low-birth-weight babies in Brazil and India were found to have a risk of dying from pneumonia three to eight times higher than children of average weight; malnourished children are, on average, twice as likely to die. Two other promising interventions are the promotion of breast-feeding and the correction of vitamin A deficiencies. The benefits of breast-feeding are well established. In Brazil and Peru, for instance, non-breast-fed infants had a greater risk of pneumonia, 3.5 and 5 times, respectively. While less comprehensive than those regarding ARI, studies from four countries on vitamin A deficiency suggest that it may increase the incidence of pneumonia.

35. Finally, links between environmental risk factors and ARI are becoming increasingly clear. While more research is needed, especially in developing countries, factors already identified include indoor and outdoor air pollution, exposure to passive smoke, overcrowding and chilling. During the next few years, steps can and should be taken to make the environment less dangerous for children and, at the same time, less conducive to ARI.

J. Similarities with efforts to control diarrhoeal diseases

36. While pneumonia must be treated sooner than diarrhoeal disease, thus calling for greater skill on the part of the health worker and better access to antibiotics, there are also many similarities. Mothers and families can play a key role in recognition and prevention of the disease. Health workers can be taught case management. Increased fluids and continued feeding are essential to successful treatment. At the same time, a few areas can be substantially improved. For example, linkages with nutrition must be fully understood and interventions developed on this basis. Prevention must also be emphasized early and included as an essential element in national control programmes. Finally, the synergism of various interventions (e.g., CDD, ARI, expanded programme on immunization, micronutrient deficiencies) must be fully exploited, both in the development of basic strategies and approaches and in the implementation of control activities.

II. UNICEF SUPPORT TO NATIONAL ARI PROGRAMMES

A. Objectives

37. UNICEF involvement in ARI control activities has the following main objectives:

(a) To reduce mortality due to pneumonia in children under five years of age;

(b) To reduce the inappropriate use of antimicrobials and other drugs, mainly cough and cold medicines, for the treatment of ARI in children;

(c) To reduce the incidence of acute lower respiratory infections, particularly pneumonia.

B. Strategies

38. To achieve those objectives, UNICEF will promote three main ARI control strategies in the 1990s:

(a) Standard case management to reduce mortality through proper diagnosis and the appropriate use of antibiotics for the treatment of acute lower respiratory infections, while discouraging the abuse of antibiotics and other drugs for upper respiratory infections;

(b) Immunization to reduce both morbidity and mortality. At present, only measles, pertussis and diphtheria can be prevented by immunization, but vaccines against pneumococcus and Haemophilus influenzae, the main bacterial agents of pneumonia in children, are actively being developed;

(c) The reduction of risk factors for pneumonia to reduce the incidence of the disease. This includes factors affecting both individual children (e.g., with low birth weight and malnutrition) and the environment (e.g., indoor and outdoor air pollution, passive smoke, overcrowding and chilling in young infants).

39. In developing these strategies, UNICEF will continue to encourage national ARI programmes to give priority to training health personnel in standard case management; improving home care for ARI, emphasizing the role of caretakers in recognizing signs of illness, seeking appropriate care and complying with treatment instructions; increasing the involvement of CHWs; and identifying and responding to the major risk factors for ARI among young children. The drug supply system, especially at district and peripheral levels, will receive special attention with a view to establishing affordable and sustainable systems on the basis of the Bamako Initiative.

III. RECOMMENDATIONS

40. The Executive Director recommends that, in order to reduce morbidity and mortality caused by ARI, especially in infants and children under five years of age, the Executive Board endorse the following actions, and that the progress made be reported annually in the report of the Executive Director:

(a) Support to ARI control at the national level. While inclusion of ARI control activities in area-based primary health care initiatives, or as part of initial efforts to strengthen district-level health services, is encouraged, UNICEF involvement will be based on support to national ARI control programmes and control activities throughout the country, integrated with other efforts to reduce and prevent infant and young child mortality and morbidity;

(b) Building on existing structures. During the past few years, efforts in some countries to expand immunization coverage have considerably strengthened supply distribution, service delivery networks and other aspects of national health systems. ARI control activities will take full advantage of these improvements and be fully integrated into the basic package of health services offered by peripheral and first-level facilities;

(c) Establishment of clear national policies and plans of action. National policies and plans of action are an essential first step in the development of ARI control programmes. UNICEF will limit support to ad hoc ARI control activities (i.e., the provision of drugs) in countries where this process is not completed or well under way;

(d) Sustainability of ARI control programmes. Effective ARI control requires a functioning health system that can regularly train and supervise staff, provide adequate quantities of antibiotics to all health facilities and handle severe pneumonia or illness through referral to major hospitals. In countries where health systems cannot meet this challenge, emphasis will be given to strengthening the operation and management of health facilities (especially at district and local levels) before ARI control activities are initiated. The establishment of drugs logistics systems, in line with the principles of the Bamako Initiative, will also be encouraged. This process should result in greater community involvement, management and control over local health facilities;

(e) Involvement of CHWs in the diagnosis and treatment of pneumonia. The incidence of death from pneumonia is highest among young children (e.g., under six months of age) and in the poorest, most isolated areas. For these reasons, the involvement of CHWs in locating, treating and referring cases of pneumonia is essential to the long-term viability of control efforts. As soon as adequate services are established in first-level health facilities, national programmes will be encouraged to identify VHWs or CHWs who can be trained either to refer cases to the health system or to act as front-line providers of standard case management;

(f) Full involvement of mothers and communities. Mothers must be taught to recognize signs of serious illness, seek help when necessary and comply with treatment instructions. To do so, efforts must be made to find out what mothers already know and reinforce healthy practices while discouraging negative ones. Without the full involvement of communities, the youngest, most vulnerable children cannot be reached on a sustained, reliable basis. Communications efforts will be promoted to support these activities.

41. During the next few years, UNICEF will continue to provide support in the following areas:

(a) Adaptation of technically sound norms for diagnosis and treatment, including their application by such health personnel as CHWs, as appropriate;

(b) Training and supervision in the standard case management of ARI, both for health workers at the clinic level and at first-referral facilities and for CHWs in various settings;

(c) Provision of appropriate drugs in reasonable quantities at the initial stage. One of the key objectives of all ARI programmes must be to provide the right drug, to the right child, at the right time, for the right duration. This will be built into the drugs logistics system based on the principles of the Bamako Initiative and supported, controlled and managed by the communities;

(d) Development of sound communication strategies that are fully integrated into national programmes and supportive of reliable, well-established services. First priority will be given to the design and

production of teaching and information materials for use by health workers in face-to-face interaction with caretakers of young children. Once standard case management is well established at first-level health facilities and, where appropriate, among CHWs, more extensive, innovative communication activities will be developed, through radio, television and other mass media;

(e) Provision of appropriate technology for the diagnosis and treatment of pneumonia, including timers for counting respiratory rates and oxygen concentrators for use at small hospitals and clinics;

(f) Prevention of pneumonia by ensuring access to immunization, good nutrition and a healthy environment and by promoting breast-feeding. While the initial emphasis of control programmes must be on improving case management to reduce ARI-related mortality, efforts must begin early to reduce the incidence of the disease. Immunization against measles and pertussis is the most effective preventive measure available at present. The development of vaccines against pneumococcus and Haemophilus influenzae will also receive priority support. Furthermore, UNICEF will support the improvement of interventions to reduce both host and environmental risk factors (e.g., better nutrition and reduced air pollution).

IV. THE CHALLENGE AHEAD

42. To meet the World Summit goal of a one-third reduction in ARI-related deaths, access to standard case management must be raised from its current 20 per cent to 60 per cent by the year 2000. This means that 6 out of 10 children suffering from ARI episodes will receive proper treatment, resulting in the prevention of approximately 15 million deaths by the end of the decade. Given the current status of most ARI control programmes and the many other health problems demanding attention, this is a formidable challenge.

43. While significant progress will be made through standard case management and other measures, it is likely that major breakthroughs in the control of ARI will depend on the degree of success in the following three areas:

(a) The capacity of health workers and providers at the peripheral level to diagnose and provide front-line treatment through the use of antibiotics (given proper training and close supervision);

(b) The availability of appropriate and affordable drugs through a national drugs logistics system;

(c) The empowerment of the people with information and knowledge on the control of ARI.

Notes

1/ Among children between the ages of two months and five years old, approximately 2.8 million deaths are from pneumonia, 800,000 are caused by neonatal pneumonia, 480,000 are associated with measles and 260,000 are associated with pertussis.

2/ ARI includes all infections of the respiratory tract from the nose and throat down to the lungs and including the ears. This includes ear infections, sore throat, common cold, bronchitis, croup, bronchiolitis and pneumonia, which is an infection of the lung itself. The most frequent ARI is the common cold and the most severe is pneumonia.

Annex

REVIEW OF UNICEF ASSISTANCE TO NATIONAL ARI CONTROL EFFORTS

1. Most UNICEF offices are supporting ARI control efforts at either the national or subnational level. While this support varies considerably among countries, trends are evident both within and across regions. Based on 1991 annual reports and other programme documents, the most important trends are outlined below.

2. National ARI control programmes are least developed in West and Central Africa. In several countries (Cape Verde, the Central African Republic, Mali and the Niger), Governments recognize the problem of ARI, but for various reasons are postponing the initiation of formal control programmes. In others (Benin, Guinea, Côte d'Ivoire and Togo), ARI control activities are integrated into more general efforts to strengthen district-level health services and the management of the health system at various levels (through implementation of the Bamako Initiative strategy, etc.). In the Gambia, two studies have been undertaken to assist development of the national programme, one of which was an ethnographic study of mothers' attitudes and practices related to ARI. Only a few countries (Gambia and Nigeria) have developed clear national policy documents or comprehensive plans of action. Despite this, several are requesting UNICEF support for such activities as increased provision of antibiotics to health facilities and production of communication materials. In the absence of clearly defined policies, some of these ad hoc initiatives are causing confusion and reinforcing negative practices (over-prescription of drugs) rather than improving health services.

3. A similar situation exists in Eastern and southern Africa, although ARI control programmes are slightly more developed there than in other parts of the continent. Most countries have initiated control activities and there is greater awareness of the need for national policies and plans of action. Only a few, however, have moved past the initial stages of implementation and the tendency persists to equate ARI control with the provision of essential drugs or the establishment of village pharmacies, rather than with the development of comprehensive programmes. In some of the countries in which programmes are more advanced (Botswana, Lesotho, Swaziland and Zimbabwe) emphasis is on integration of ARI control activities with such other health services as the treatment of diarrhoeal diseases and malaria and on the development of appropriate communication materials.

4. In South and Central Asia, many countries have already developed national ARI control policies (Bangladesh, India, Nepal, Pakistan and Sri Lanka). Emphasis is on training health workers, including doctors and nurses (through the establishment of ARI training units at major hospitals) and paramedical personnel at peripheral health facilities (through three- to five-day clinical management courses offered at small hospitals and health facilities). In a few countries (Bangladesh, India and Pakistan), research has been done on mothers' attitudes and practices concerning ARI, and the results have been

used to improve training and communication efforts. In almost all countries, ARI control programmes are being phased in, beginning in certain districts and gradually expanding to other areas of the country.

5. In several countries in East Asia and the Pacific, ARI control programmes are also well advanced. National policies and treatment guidelines have been developed in China, the Lao People's Democratic Republic, Fiji, Papua New Guinea, the Philippines, Solomon Islands, Thailand, Tonga, Vanuatu and Viet Nam, and treatment protocols are either completed or in the process of adaptation in Cambodia, Indonesia, Thailand and Viet Nam. There is strong emphasis on operational research, with studies completed or under way in Cambodia, China, Indonesia, Myanmar, the Philippines, Thailand and Viet Nam. Most of the studies are designed to increase understanding about health worker practices and/or mothers' attitudes and beliefs concerning ARI. The training of health workers is also emphasized in many countries.

6. In the Americas and the Caribbean region, a number of ARI control programmes have been under way for some time. In these countries, emphasis is on improving communication strategies in Bolivia, Haiti, Honduras and Mexico and ensuring adequate drug supplies in peripheral health facilities in Bolivia, Honduras, Mexico, Paraguay and Peru. A number of countries (Dominican Republic, Ecuador and Honduras) are experiencing problems or delays in the revision of treatment protocols, which have hampered progress of control efforts. Control programmes in the Americas and the Caribbean are also involving CHWs in the assessment and treatment of ARI, including pneumonia.

7. In the Middle East and North Africa, several countries have developed national ARI control policies and initiated activities in one or more areas (Egypt, the Islamic Republic of Iran, Oman, the Sudan and the Syrian Arab Republic). While attention to training continues at all levels of the health system, a few countries are also pursuing innovative strategies to prevent pneumonia (an anti-smoking campaign in Oman) and to conduct research on beliefs and practices at both the health facility and household level (Egypt). In others, official control programmes have been postponed or delayed because of war and civil unrest (Iraq).

8. Based on this review, a number of general trends can be identified:

(a) In all regions, ARI figures among the top three causes of morbidity and mortality. Furthermore, it often accounts for the largest number of hospital admissions and out-patient consultations (up to one third of all cases in many countries);

(b) Recognition of the seriousness of the ARI problem is increasing in many countries. Wherever this occurs, Governments have approached UNICEF for both technical and financial support in planning and implementing control efforts. The ability of UNICEF offices to respond to these requests has a profound influence on the development of effective national control programmes;

(c) While many countries begin by developing national policies and plans of action, several others are initiating control activities before this process is completed. The result is often unsatisfactory, such as an increased availability of drugs without proper training of personnel and/or dissemination of treatment and prevention messages without adequate services available in the health system;

(d) While a number of national control programmes recognize the potential importance of CHWs in the assessment and treatment of ARI, few have actually begun to involve them on a significant scale. UNICEF support in this area is likely to increase considerably during the 1990s.

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REPORT ON COLLABORATIVE PROGRAMMING ACTIVITIES OF THE UNITED NATIONS CHILDREN'S FUND AND THE UNITED NATIONS POPULATION FUND

Joint report of the Executive Directors of UNICEF and UNFPA*

SUMMARY

This joint report of the Executive Directors of UNICEF and UNFPA on collaborative programming activities of UNICEF and UNFPA is submitted in response to Governing Council decision 90/35, which requested the Executive Director to submit a joint report, based on specific country studies, to the thirty-ninth session of the Council. The report comprises five sections. The first examines the need and rationale for close UNICEF/UNFPA collaboration. The second part of the report analyses past and existing collaborative programming activities at the country level, based on case studies conducted jointly by UNICEF and UNFPA in selected countries in all regions, and in consultation with other relevant United Nations organizations, notably WHO and the International Bank for Reconstruction and Development. This section reviews lessons learnt in collaboration in specific substantive areas and examines programming processes. The third section of the report reviews headquarters-level collaboration in support of country programming. In the fourth section, collaboration between UNICEF and UNFPA is placed in the broader context of the overall United Nations system and other donors. The final section outlines specific steps that UNICEF and UNFPA have agreed to undertake to further strengthen collaboration. This joint report will also be presented by the Executive Director of UNICEF to the UNICEF Executive Board in June 1992, in response to Executive Board decision 1990/36.

* Also issued as a document of the Governing Council of the United Nations Development Programme under the symbol DP/1992/28.

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INTRODUCTION

1. This report has been prepared in response to Governing Council decision 90/35A, which requested the Executive Director to submit to the Council at its thirty-ninth session a joint report on collaborative programme activities with the United Nations Children's Fund (UNICEF) and -- as far as possible -- other organizations, notably the World Health Organization (WHO) and the International Bank for Reconstruction and Development (hereinafter the World Bank). The report is also in response to UNICEF Executive Board decision 1990/36, which requested the UNICEF Executive Director to submit to the Board at its regular June 1992 session a joint report on collaborative activities with UNFPA.

2. This report has been jointly prepared by UNICEF and UNFPA. As requested by the Governing Council, it takes into account specific country studies, which have been carried out by selected field offices of the two organizations, in consultation with other concerned organizations, particularly WHO. The joint effort required to prepare this report has, in and of itself, further strengthened the links between UNICEF and UNFPA, and suggested several additional measures that the two organizations can implement to improve collaboration further. These measures are outlined in the last section of this report (para. 73). This report should therefore be viewed as part of the process to facilitate and accelerate collaboration and to ensure that it becomes an integral part of the activities of each organization.

3. UNICEF and UNFPA believe that this report, with its country-based studies, fits positively into the growing tendency within the United Nations system to give increasing recognition to aid coordination and development cooperation as reflected, inter alia, in the landmark General Assembly resolution 44/211. Such recognition is based on the premise set forth by the General Assembly, and fully endorsed by both UNICEF and UNFPA, that Governments have the primary role for coordination at the national level. UNICEF and UNFPA, like other partners in the development process, assist Governments, upon request, in strengthening national capacities in this respect. This study, therefore, seeks to identify ways in which UNICEF and UNFPA, in cooperation with all others concerned, can better collaborate "in order to enable the recipient Governments to exercise their management and coordination responsibilities and strengthen their national capacities" (resolution 44/211, para. 14).

4. It is understood throughout this report, in discussing UNICEF and UNFPA collaboration in the areas relevant to health, that such collaboration takes place in the context of the policy and technical framework established by the governing bodies of the World Health Organization. Even where not specifically noted, the technical content, norms, standards and strategies of activities to develop health programmes, both with respect to maternal and child health and family planning (MCH/FP) in particular and primary health care in general, are those established by the WHO and its governing bodies. In this context, the collaboration of UNICEF and UNFPA with WHO has a qualitatively different status from the collaboration or participation among other agencies or organizations within the United Nations system, and is reflected in the close linkages between the three, as described in this document. This report should also be read in the context of the ongoing work by UNICEF and UNFPA to actively support important collaboration initiatives of the Office of the Director-General for Development and International Economic Cooperation (DIEC), the role of the Resident Coordinators at the country level and the initiatives of the Joint Consultative Group on Policy (JCGP).

5. The present report contains five sections. The first section reviews the need and rationale for maintaining close collaboration between UNICEF and UNFPA. The second and main part of the report examines past and present experience in collaborative programme activities at the country level and analyses programming processes as facilitating and constraining such collaboration. The third part of the report examines collaboration at the headquarters level, including the ways in which such collaboration supports collaborative action at the country level. In the fourth section, UNICEF/UNFPA collaboration is placed within the wider context of development cooperation, examining the important links and roles of a number of other agencies and organizations. The last section of the report outlines a number of measures agreed to by UNICEF and UNFPA to further strengthen collaboration. The report also contains an annex highlighting the common goals for WHO, UNICEF and UNFPA, adopted by the three organizations in May 1990.

I. NEED FOR COLLABORATION

A. Emerging trends in UNICEF and UNFPA

6. Both UNICEF and UNFPA have been rapidly evolving over the last decade in response to changing needs of the countries they assist and to the lessons learnt from past programming experiences. In the case of UNICEF, this evolution has led to a focus on goals and strategies for improving the health and welfare of children as the basis for guiding the organization's work and for assessing its achievements. As a result, UNICEF is committed to playing an important role in helping developing countries to attain an ambitious but achievable set of goals. Achieving these goals is far beyond the capacity of UNICEF alone -- the goals are wide in scope and large in scale -- and requires maintaining close links with organizations that have mandates in areas complementary to that of UNICEF.

7. As the UNICEF management and Executive Board have clearly recognized, UNICEF depends on a series of "strategic alliances" -- close links with partners able to add to or complement UNICEF's own activities. Close collaboration with UNFPA should be and is clearly an integral part of this approach. UNFPA's population activities complement and reinforce UNICEF's own work. Some areas of UNFPA's mandate, however, extend beyond UNICEF's into activities that are necessary elements of achieving the goals and strategies of the Declaration and Plan of Action of the World Summit for Children. Along these lines, in 1990, UNICEF's Executive Board passed a Resolution on Family Planning (1990/7) which recognized the positive impact of family planning on the well-being of mothers and children and the necessity of "full cooperation in the field of family planning with other relevant United Nations programmes, each within its own mandate, notably those of UNFPA and WHO". Similarly, as part of this effort, UNICEF welcomed the request of both the UNDP Governing Council and its Executive Board to prepare a joint study of UNFPA/UNICEF collaboration.

8. In a similar vein, UNFPA has also considerably evolved over the last decade. It has intensified its focus on the underlying determinants of population trends, such as those that concern the role and status of women. Further, in its work in the MCH/FP field, UNFPA has continued to shift to a broader and more analytical approach to programme development, one based on careful evaluation of past achievements and constraints and formulation of an overall long-term population strategy. The UNFPA Executive Director has long promoted such a comprehensive approach to providing MCH/FP services within the context of overall primary health care, focusing UNFPA inputs on reproductive health, including family planning. Close

coordination with all organizations and donors active in the field has become a cornerstone of UNFPA programming. As a result, UNFPA also warmly welcomed the Governing Council's request for a joint study.

B. Complementarity of UNICEF and UNFPA

9. It is the philosophy of the United Nations system's operational activities, as set forth in General Assembly resolution 44/211, that coordination is ultimately the responsibility of the recipient Government and that to support that responsibility, the United Nations system must have effective interagency collaboration. In order to ensure a coherent response to national plans and priorities, United Nations organizations should actively seek complementarities in their respective mandates and operations and adopt more integrated and coordinated programmes of development cooperation. In short, they should "increase their efforts directed towards integrated programming under the leadership of Governments" (44/211, para. 17(f)).

10. The activities reviewed for this report clearly show that this philosophy is particularly relevant for UNFPA/UNICEF efforts. In each of the fields of activity they share, UNICEF and UNFPA provide only a small portion of overall expenditures (and indeed only a small portion of external resources). At the same time, the two organizations share much in common and have many areas of mutual reinforcement in their respective mandates. By emphasizing, for clarity's sake, the obvious areas of complementarity (and by systematically analysing and presenting ways to enhance that complementarity), UNICEF and UNFPA can greatly enhance a Government's ability to achieve its development priorities.

11. Within the United Nations system, Member States have defined the role of WHO as the directing and coordinating authority on international health work, and in the field of health WHO is required to provide technical cooperation. UNICEF has been identified as the lead agency within the United Nations dealing with all matters related to children and their needs. The responsibilities of UNFPA have been defined in terms of building up capacity to respond to needs at all levels in the population and family planning fields, of promoting awareness of population problems, of providing assistance to developing countries at their request and of playing a leading role in the United Nations system in promoting and coordinating population programmes.

12. In the field of MCH/FP, the objectives of WHO, UNICEF and UNFPA converge in relation to goals for women and children in the 1990s. As is illustrated in the annex, WHO, UNICEF and UNFPA agreed in May 1990 on common goals in the areas of MCH and FP for the year 2000, based on the Declaration of the World Summit for Children and the Amsterdam Declaration, adopted by the International Forum on Population in the Twenty-first Century.

13. In addition to complementarity of goals, UNICEF and UNFPA support many complementary or similar activities. This convergence is further reinforced by the fact that both organizations draw upon the same consistent source of technical and policy guidance from WHO. Thus, both organizations provide training for various categories of health personnel, seek to sensitize potential providers of care outside the health sector, and strengthen the networks that provide health services and improve the quality of health care. Similarly, UNICEF and UNFPA emphasize the community-based delivery of services and engage in a wide range of awareness creation, social mobilization and education activities, often targeting the same parents and couples, service providers and communities at large. Since related target groups are being reached by UNICEF and UNFPA, this provides an excellent opportunity to synchronize and coordinate these efforts so

as to help Governments deliver a more comprehensive package of integrated interventions and so that the inputs of one organization reinforce those of the other. For example, UNICEF programmes related to immunization, diarrhoeal diseases and respiratory infections should also be part of an overall national primary health care plan, including its MCH/FP component. Likewise, where UNFPA supports family planning interventions, these should be part of a comprehensive national MCH/FP strategy.

II. FIELD LEVEL COLLABORATION

A. Programme processes

14. UNFPA and UNICEF share a number of similarities in structure and in programming processes, which can contribute significantly to effective collaboration. There are also some institutional differences. In some cases, these present potential obstacles and thus require special attention to overcome them. In other cases, the differences in mandate, structure or programming processes can actually enhance the impact of collaboration.

Field structure

15. While the size of UNICEF and UNFPA staff and programmes differ considerably at headquarters and in the field, UNICEF and UNFPA share a similar institutional structure -- a focus on country-level activities administered through a network of country offices, with a support role for headquarters. To illustrate the point, one should note that UNICEF has over 85 per cent of its staff in the field and UNFPA 70 per cent. The value of this decentralized country-focused approach and its contribution to interagency collaboration cannot be overestimated. This field orientation differentiates UNFPA/UNICEF collaboration from that between each organization and some of the other significant partners in the MCH field, such as WHO (which has a combined headquarters and regional structure) and the World Bank (which has a more headquarters-based structure). In the case of the latter two organizations, the lack of substantial field presence has proven to be a significant impediment to common action. However, as has been demonstrated in Bangladesh, for example, with a willingness and sense of common purpose, such differences in structure need not always be an obstacle to coordinated country support. It may also be that by "teaming up", UNICEF and UNFPA can more easily coordinate activities with other partners (e.g., a common initiative that is larger than individual efforts may justify travel or other types of links with other organizations' regional offices or headquarters).

16. In addition to its country-based approach, UNICEF sometimes has suboffices within a country and does programming at the provincial or state level (e.g., Sudan and India). The fact that UNFPA is less frequently based at this level (it has fewer staff and a smaller programme) has been cited as an obstacle to communication. Furthermore, UNICEF has regional offices for backstopping country activities, whereas UNFPA does not. It is felt that these divergencies, while real, can be turned to an advantage. UNICEF's greater presence at subnational levels can open new channels for UNFPA assistance -- if the two organizations make special efforts to establish links that bridge the physical distance. It is the intention of both Executive Directors to establish special mechanisms to achieve this.

17. The different size of field offices is a marked distinction between the organizations. For example, in India, UNICEF has 110 Professionals (in 13 offices), while UNFPA has 3 Professionals (all based in New Delhi). In Sudan, UNICEF has 30 Professionals (including provincial offices) while UNFPA has 3

Professionals (all in Khartoum). Contrasts in the level of field staff also exist. In some cases, this can prove to be an obstacle, particularly since interagency collaboration is labour intensive and especially draws upon senior management time. While these differences necessitate a sense of realism regarding the potential scale of common activities, at the same time such differences -- if properly addressed and taken into account -- can produce a positive impact in areas of common focus. For example, UNICEF's size and decentralized approach permit it to undertake local procurement -- the procurement of national goods for the country programme (it also procures national goods for country programmes in other developing countries). This is often highly cost-effective and helps ensure the provision of supplies suited to local needs. UNFPA and UNICEF intend to strengthen this form of collaboration.

Programming processes

18. While UNICEF and UNFPA have had somewhat dissimilar approaches to programming, the evolution of UNFPA's programming process over the past few years has significantly narrowed these differences. Both UNICEF and UNFPA have increased their focus on a country-programme approach. For UNICEF, this approach emphasizes the establishment of clear programme goals, with monitorable impact targets. Assistance is then channelled, in a highly flexible manner, to those activities that have the greatest potential impact. Overall, the emphasis is on "management by objective" in which UNICEF assistance is formulated and assessed on the basis of the ultimate impact it will have, usually on a national scale. Thus, there are no "UNICEF projects", nor does UNICEF execute projects. Rather, UNICEF assistance contributes a small but (it is hoped) highly catalytic part to government programmes.

19. In UNICEF, the focus is on country programmes, through which some 90 per cent of UNICEF's assistance is provided, usually in a five-year framework. The process of preparation typically takes 18 months, beginning with an analysis of the situation of children in the respective country. This Situation Analysis reviews the priority needs of children and the strengths, weaknesses, and gaps in the national response to meet these needs. Then follows work with the Government (along with other partners) on a strategy of response in which goals and objectives for the 1990s become a critical element. Consensus goals at the international level, especially those set forth in the Declaration and Plan of Action of the World Summit for Children, are particularly drawn upon. Only at the end of this process comes the planning of how UNICEF's own limited resources can best be used in support of, and sometimes as a catalyst for, the main thrusts of national action.

20. For UNFPA, the programme approach stresses the importance of establishing an overall national population programme framework with long-term national objectives. Such a framework provides the much-needed coherence for all inputs, both from Government and all donors, in the national programme. The programming process is very similar to that of UNICEF, starting with a Programme Review and Strategy Development (PRSD) exercise to assess progress made during the previous country programme, determine national issues and needs, identify constraining factors, and develop an overall strategy to address such needs. The PRSD process is a collaborative UNFPA/Government exercise, undertaken in close coordination with all other donors and NGOs active in population and related activities in the country, aiming at reaching a consensus on a comprehensive strategic framework for a national programme. Like UNICEF, UNFPA refers in this process to the consensus goals and objectives on population issues reached at the international level, particularly those embodied in the Amsterdam Declaration.

21. Beyond programme formulation, UNICEF and UNFPA policies and procedures differ in terms of programming decisions and release of funds for specific activities. The UNICEF field office has considerably more decentralized authority in this regard than the UNFPA field offices. UNICEF and UNFPA also differ in how they deliver their assistance. For example, UNICEF implements its programmes through the Government, whereas UNFPA relies on a broad range of executing agencies, including the Government, United Nations specialized agencies, and NGOs. Furthermore, the two organizations often have different government counterparts. UNFPA's overall government counterpart is the aid coordinating ministry, often the Ministry of Planning. UNICEF usually deals directly with sectoral ministries.

22. Overall, the review carried out for the present study indicates that each organization does consult and participate in the other's programme review and planning meetings. However, there is considerable potential to expand and systematize such consultation and participation. As part of this effort, the JCGP organizations (which include UNFPA and UNICEF, along with UNDP, the International Fund for Agricultural Development (IFAD) and the World Food Programme (WFP)) have agreed to harmonize their programming cycles around government planning cycles. Already, several rounds of adjustments of programming cycles have been undertaken, and this will be a continuous effort. Both UNICEF and UNFPA have collaborated closely with WHO in the developing and testing of various programming and evaluation approaches and methodologies in a number of countries. These efforts will be continued and further strengthened.

Programme reviews/situation analyses

23. Both organizations emphasize the role of an extensive and explicit assessment of the situation as the first step in programming and in channelling assistance to national efforts. Fundamentally, both organizations carry out these assessments in a similar manner (including drawing upon a mix of in-country staff, national consultants and international expertise). Naturally, each organization's assessments focus on areas of their programme activities, and in many cases these will differ. However, there is a common core of activities in the MCH/FP field, and both organizations increasingly seek to consult each other during the programme review/situation analysis stage. This will become more meaningful and helpful as UNICEF and UNFPA not only synchronize their programming cycles in a greater number of countries, but also issue guidelines instructing field offices to seek every opportunity to collaborate with one another.

Support to government efforts to establish and achieve goals and strategies

24. For both UNICEF and UNFPA, national plans, including national goals and strategies, are a fundamental starting point for their programme efforts. Such plans contain a number of areas in which the two organizations could collaborate more effectively to help support government efforts. In some cases, such collaboration may be limited by the fact that the two organizations frequently work with different ministries or with different sections of the same ministry. However, this could also prove to be an advantage, since the common support and advocacy efforts of the two organizations may then support and have an impact on a broader spectrum within the national government.

25. At the international level, both organizations share a common set of goals and strategies that are drawn upon to help support national efforts. The country studies carried out by the field offices confirmed that the goals and strategies of the Declaration and Plan of Action of the World Summit for Children, along with the principles of the Amsterdam Declaration, serve as useful reference points for providing support to

national endeavours, and such directions have been spelled out in a joint WHO/UNICEF/UNDP/UNFPA letter of February 1991 issued by the chief executives of the four organizations in support of greater collaboration in the field of MCH/FP.

26. UNICEF and UNFPA's experiences have also shown that there are a number of key entry points to be supported if national goals are to be achieved. These include the national programmes of action that are being prepared to implement the commitments made as part of the World Summit for Children. A number of the goals of the Declaration and Plan of Action of the Summit are central to UNFPA and UNICEF's concerns. This is well illustrated, for example, in the interagency agreement in the Latin America and Caribbean region, which also includes the Pan American Health Organization (PAHO), the United States Agency for International Development (USAID) and others (see para. 54). Both UNICEF and UNFPA intend to actively support the preparation and implementation of these programmes, individually and as a collaborative activity.

27. The organizations also intend to focus on achieving these goals not only in their work with the sectoral ministries, but also in their support of Governments' overall development plans and policies. In particular, the two organizations plan to accelerate their efforts to collaborate in such undertakings as supporting human development initiatives, focusing on alleviating poverty, and establishing the necessary links between programme activities and national budget and resource priorities. In addition, both organizations can work individually and together to help mobilize international support to implement priority initiatives for human development in general and for the status of women in particular. UNFPA and UNICEF intend to collaborate in advocacy efforts in key fora such as World Bank donor consultations, UNDP Roundtables, and other formal gatherings where donor support can be mobilized.

Conclusion

28. Each organization has programming processes that are adapted (or are being adapted) to its particular needs and strengths. These processes are growing increasingly similar, and this should help promote collaboration. However, to ensure such collaboration both Executive Directors intend to issue guidelines that will emphasize the need for greater cross-participation in each other's programming processes. This cross-participation should begin at the earliest possible stage and explore common elements of situation analyses and programming, common areas of support to government projects, cross-participation in programme reviews and mid-term reviews, and common efforts in evaluation.

B. Collaboration in specific substantive areas

29. A review of the case studies commissioned for the preparation of this report and of other pertinent information shows that there are a number of concrete examples of successful collaboration and joint activities among Governments, UNICEF and UNFPA, as well as between each of these and other United Nations organizations, donors and NGOs. However, the review also pointed out that such collaboration is not systematic in all countries assisted by UNICEF and UNFPA, is still a rather small part of the programmes, and is not systematically reported on.

30. Collaboration among Governments, UNICEF and UNFPA seems to be most frequent in the area of MCH/FP, followed by IEC in support of MCH/FP. Examples of such collaboration are also relatively common in the area of women and development. Some, but clearly fewer, examples of cooperation can be

found in other areas, such as support for sectoral policy planning (e.g., population planning) and for youth programmes, among others. Lessons cannot be easily derived from these collaborative experiences, as many of them are rather recent. There is, however, a clear trend of increasing collaboration in that, for example, most recently formulated UNFPA country programmes now include collaborative activities with UNICEF, as this is now specifically recommended in UNFPA programme guidelines and checked at the time of programme review at UNFPA headquarters.

1. Maternal and child health and family planning

31. In the area of MCH/FP, collaboration between UNICEF and UNFPA has been more prevalent in training of various categories of health personnel than in other types of activities. Very often this collaboration has involved the training of traditional birth attendants (TBAs), including training in family planning. For example, in Nigeria and Sudan both organizations have provided complementary inputs to the same national TBA training programme. In the United Republic of Tanzania, both organizations jointly financed the training of health personnel; in Bangladesh, UNFPA is supporting training and UNICEF is providing complementary inputs for the same categories of health personnel (e.g., safe-delivery kits). In both Bangladesh and the United Republic of Tanzania, WHO has participated in this collaboration.

32. Training of health and medical personnel is clearly an area that would benefit from even more systematic cooperation not only between both by UNICEF and UNFPA but also among other donors active in the MCH/FP sector. At the initiative of the Government, and together with WHO, NGOs and other donors, this should start with a joint review of training needs. This would then be followed by the formulation of a comprehensive national training strategy that would accommodate within its framework the inputs of the various donors.

33. The case studies reveal a broad frame of collaboration providing complementary support for national MCH/FP programmes in some countries -- Bangladesh, Burkina Faso, China, Niger -- and particularly in the context of Safe Motherhood activities (Congo, Côte d'Ivoire, Mongolia, Niger, Philippines, Senegal, United Republic of Tanzania). The studies further indicate that an increasing number of countries have concrete plans for more substantive cooperation in the future (Brazil, Burundi, Guinea, Niger, Sierra Leone). For example, in Sierra Leone, UNICEF has been selected as the executing agency for a national MCH/FP project to be funded by UNFPA and modelled after the rather successful national expanded programme of immunization (EPI) supported by UNICEF. WHO will also provide technical inputs. Clearly, such efforts should be made more systematic.

34. A positive new joint initiative among WHO, UNICEF and UNFPA in Bangladesh involves a series of actions aimed at delaying age at marriage, delaying first births and lengthening the intervals between pregnancies. Bangladesh provides a good example of how both child health and maternal health/family planning benefit substantially when services are integrated in a comprehensive package rather than provided separately. In Bangladesh, the Government has played a leading role in coordinating the delivery of such integrated services, and different organizations have been resourceful in pursuing substantive and meaningful collaboration, giving national development needs greatest priority. In India, the Government, with UNFPA support, has included a family planning component into the integrated child development services supported by UNICEF. Also in India, the Government, together with UNFPA support, is planning a major integrated intervention in Haryana State, which seeks, inter alia, to improve the role and status of women by providing

incentives for families to enroll and retain girl children in school. If, as expected, UNICEF and others join to support this experiment, it can provide a powerful model for replication in other places.

35. Another promising new development in collaboration is taking place in Nepal, where UNICEF and UNFPA not only have synchronized their programming cycles, but also have jointly commissioned a special effort to increase systematic cooperation. This effort is aimed at establishing institutional mechanisms to improve coordination at all stages of the programming process, identifying concrete collaborative activities in the new programme cycle and creating better understanding among the field office staff about the policies and programmes of each organization. A survey was conducted among all UNICEF and UNFPA staff in Nepal, followed by a joint workshop. The workshop identified a number of areas suitable for collaboration in MCH/FP service delivery and training, as well as in IEC and advocacy. The goal is to test the effectiveness of the institutional mechanisms of collaboration that have been built into newly established selected projects. Nepal also provides another positive example of how UNICEF experience in immunization can contribute to other MCH/FP components. Indeed, the Government has agreed to incorporate family planning into its health activities, and village health workers have included family planning into their regular responsibilities. Both of these actions have greatly revitalized the country's family planning programme.

36. In some cases, UNICEF and UNFPA have collaborated to support the Government's efforts in developing and/or assessing programme strategies, and in conducting consultations on the status of the national health sector (Cuba, Indonesia, Uganda, United Republic of Tanzania, Yemen as well as in those countries covered by the Latin America and Caribbean region interagency agreement -- see para. 54). Yemen provides a recent positive example of both UNICEF and UNFPA taking an active role, together with the Government, in convening a national workshop on the Yemen National Population Strategy. The workshop underscored the complementarity of the goals of the World Summit for Children and those of the Amsterdam Declaration on population and family planning.

37. Yemen is also a good illustration of collaboration in various aspects of MCH/FP. It shows how close cooperation among a wide range of concerned parties -- the Government, UNICEF, UNFPA and a number of other organizations and donors -- has helped to place more emphasis on women's health and family planning within MCH services that had previously been almost exclusively targeted at serving infant and child health needs. Cooperation between UNFPA and UNICEF in Yemen has facilitated the Government's move towards a more comprehensive and integrated package of MCH/FP service delivery at all levels. UNICEF and UNFPA will support the Government's efforts to upgrade the managerial capacity of the national MCH/FP Department, will jointly sponsor training for paramedical staff using a unified training module and will coordinate UNFPA-assisted maternal health programmes with EPI and anti-diarrhoeal programmes supported by UNICEF. This comprehensive coordination of UNICEF and UNFPA programmes will also include interpersonal communication and IEC activities. UNICEF will provide support for the mass media component of the UNFPA programme.

38. The Government of China, UNICEF, UNFPA and WHO, as well as a non-governmental organization -- the Program for Appropriate Technology in Health (PATH) -- are working together to upgrade services at the grassroots level in 300 of the poorest, most remote counties in China. The principal objective is to strengthen the three tier -- county, township, village -- MCH/FP service delivery network. So far, in terms of substantive issues, this undertaking has been promising, and initial misunderstandings about financial, accounting and procedural concerns have been clarified. This experience shows that, before joint funding

is undertaken, great care should be taken to review and clarify in advance each organization's financial and accounting procedures, as well as to agree on roles and responsibilities.

39. A noteworthy area of collaborative activities is the increasing effort to implement Safe Motherhood programmes. There are now several countries, particularly in sub-Saharan Africa, that are initiating comprehensive activities to reduce maternal mortality by improving the quality and effectiveness of MCH/FP services, as well as by enhancing the status of women. Such collaborative activities are largely the result of the international and regional conferences on Safe Motherhood, which have been co-sponsored by a number of organizations, including UNICEF, UNFPA, the World Bank, WHO and UNDP. An excellent example of national-level follow-up action is provided by the Tanzanian Safe Motherhood Initiative, which has developed a National Plan of Action, with inputs, inter alia, from UNICEF, UNFPA and a non-governmental organization, Family Care International. This Plan of Action was among the basic documents used in the preparation of the new country programmes (1992-1997) of both UNICEF and UNFPA, with the two programmes providing common support for training of health personnel and with UNFPA undertaking special efforts to ensure quality family planning information and services in all of UNICEF's operational areas. The two organizations have also agreed to cooperate more actively in ensuring the availability of gender-specific data and of information pertaining to child and maternal mortality.

40. Useful lessons can already be derived from the experience in the United Republic of Tanzania, not the least of which is to show that meaningful and concrete collaboration can be achieved at the field level when all parties are committed to it, and it is done with care. The lessons also show that such collaboration is facilitated by synchronizing programme cycles and by supporting the development of a country-wide national MCH/FP strategy (in this case the Safe Motherhood Action Plan) which provides a coherent framework for all donor inputs. The Tanzanian experience reveals important constraints as well. These include, among others, a limited national capacity for effective coordination; differences in operational policies, modalities and practices; and differences in the sizes of staffs among the various parties concerned.

41. Yet another concrete area for collaboration is the WHO/UNICEF Bamako Initiative, which seeks to revitalise and strengthen basic health delivery systems and to assist countries in the financing and delivery of essential drugs at the local level. Further to policy and technical exchanges between UNICEF and UNFPA at the headquarters level, UNFPA requested all of its field offices to carefully consider opportunities for cooperation with their UNICEF counterparts in the context of the Bamako Initiative. Only limited progress has been made so far, but there is potential for more extensive cooperation in future, particularly in conjunction with new programme and/or project cycles (Cameroon, Lesotho, Sudan, Zaire). Similarly, in the area of distribution of commodities, the efficient logistics networks supported by UNICEF provide an excellent ground for further cooperation. Some collaboration on the procurement, use and maintenance of vehicles and on the use of logistics networks have taken place in Burkina Faso and Nigeria, and a promising plan exists in Yemen to include contraceptive distribution as an integral part of the Government's EPI commodity-distribution network.

42. In the area of HIV/AIDS, both UNICEF and UNFPA support the lead role and efforts of the WHO Global Programme on AIDS (GPA). Nevertheless, there are only limited concrete cooperative activities at country level at present. In a few cases, UNICEF and UNFPA report the need for joint AIDS control and prevention strategies (Côte d'Ivoire, the Philippines, Sudan, Uganda). In the Philippines, UNICEF and UNFPA envisage a collaborative MCH/FP/AIDS prevention and control project, which would be the first of

its kind in the country. In Uganda, the two organizations have indicated the strong need to collaborate to support the Government in establishing a commission on AIDS.

2. Information, education and communication

43. The area of information, education and communication, which includes advocacy, awareness creation and social mobilization, is another important area with considerable potential for UNICEF/UNFPA coordination and collaboration. Some promising examples of such collaboration already exist. However, as in the case of MCH/FP activities, there is considerable potential for greater systematization and regularization of the process. It should not be left to depend upon specific initiatives by someone from the Government, UNICEF or UNFPA, and must not be ad hoc in nature and limited to a relatively small number of activities.

44. Among the positive examples, India, in the State of Rajasthan, provides a good case of successful collaboration achieved through purely informal means, but yet rather regular in nature, due to the strong commitment of the concerned government staff. The Government IEC Unit, supported by UNFPA, also coordinates IEC work with UNICEF and makes sure that, whenever possible, the activities of the two organizations complement one another. Active cooperation in IEC work has included such activities as providing health education in schools, producing training manuals and carrying out a joint advocacy campaign against child marriage.

45. Other examples of collaboration in IEC include planning meetings to coordinate IEC efforts (Burkina Faso), providing joint financing for IEC materials (Nigeria), and providing common inputs to specific campaigns, such as promoting breastfeeding (Bangladesh) and Safe Motherhood, and combating harmful traditional practices (Burkina Faso). While the IEC activities of UNICEF and UNFPA are rather similar in strategy, modalities and target audiences, UNICEF often has a comparative advantage in more effectively reaching target groups in remote and hard-to-reach areas. Many UNFPA field offices wish to take advantage of UNICEF's advocacy, social mobilization and communications/social-marketingcapabilities.

46. A number of countries (Brazil, Cameroon, India, Mexico, the Philippines) have indicated their intent to increase collaboration in IEC in support of Governments' efforts to produce information and education materials, to integrate population education and family planning messages into other health messages and to mobilize support for integrated MCH/FP interventions. The area of IEC also offers examples of potential collaboration with other organizations. For instance, in the area of school health education, the World Bank will support government efforts to upgrade the Directorate of School Health in Cameroon, while UNFPA will adapt manuals developed within the UNICEF-assisted programme and disseminate them widely.

3. Women in Development (WID)

47. As both organizations have long supported gender-sensitive activities, there are a number of collaborative ventures already under way, and most field offices see considerable potential to expand this collaboration. In Bangladesh, for example, a rather wide-ranging and interesting cooperation has taken place between UNICEF and UNFPA. The two organizations have established a WID network, jointly conducted the 1990 situation analysis of the "Girl Child" and together assisted the Government in making national planning more sensitive to women's concerns. Together with other organizations, UNICEF and UNFPA also called on the Ministry of Education to increase the number of female teachers and stressed the need for

higher enrolment and retention of girls. As for the future, UNFPA has concrete plans to further its collaboration with UNICEF's WID project in Bangladesh.

48. Other examples of existing collaboration include common support and complementary inputs to formulate WID policies (Jamaica), strengthen Women's Bureaus, increase women's literacy, expand and improve income-generation and undertake various MCH/FP-related activities (e.g. Safe Motherhood, combating harmful traditional practices). For the future, in Bangladesh, Nigeria and Sudan, UNICEF and UNFPA plan to collaborate on activities to enhance female literacy. In Nepal, the two organizations have agreed to collaborate on activities to retain girls in secondary schools. Moreover, it is hoped that the integrated development project recently developed by UNFPA and the Indian Government in the State of Haryana will become a model not only for interagency collaboration, but also for improving the status and welfare of women and for integrated development in general.

4. Other areas

49. Other examples of collaboration include support to government studies on infant and child morbidity/mortality and on knowledge-attitudes-practice (KAP) of family planning (Tanzania, Zambia) and collaboration on other studies, such as that of living conditions in Jamaica during the period of structural adjustment. While these may seem to be rather small-scale activities, they may prove to be effective models for future cooperation on a specific, well-defined and manageable activity. Data collection for use in policy formulation has received complementary financial support in a surprisingly small number of cases. A welcome example is provided by Mozambique, where UNDP, UNICEF and UNFPA specifically planned to provide complementary inputs in conjunction with UNFPA assistance to establish a Population Planning Unit within the National Planning Committee. UNICEF then provided funding for data collection and analysis regarding women and children, and UNDP supported another component within the same overall national activity. In policy formulation and advocacy, UNICEF and UNFPA provided support to establish a population committee of government legislators in the Philippines.

50. In the area of adolescents, UNICEF and UNFPA have actively sought to collaborate in Jamaica, notably to decrease teen-age pregnancies and assist adolescent mothers in the context of activities originally supported by WHO. Collaboration on behalf of adolescents, particularly young girls, should receive much more attention in the future and should become a priority area for cooperation, in line with the joint WHO/UNICEF/UNFPA policy statement on this subject. Some efforts in this direction are under way, for example in Brazil and in South Asian countries, to delay first births. Another area that should receive more attention in the future is population, environment and development activities. With UNICEF being involved in water and environmental sanitation, and UNFPA exploring the potential in all countries for interventions addressing specific issues concerning population and the environment, there is much room for effective collaboration in this new priority area.

51. In conclusion, it is apparent that, in a number of countries, UNICEF and UNFPA already have some experience in collaboration, and in most cases the UNFPA and UNICEF field offices can easily identify a large array of country-specific activities that would benefit from more extensive and regular collaboration. There is considerable potential for expanding and systematizing these efforts. The prerequisites to successful coordination is that such coordination must be country-specific and responsive to the specific needs in each case. Headquarters can provide overall policy support and take steps to reinforce factors that facilitate collaboration and reduce existing constraints to coordination. The goal is to ensure that the strategies

pursued are in harmony with each other and that mutually supportive messages and interventions are promoted. This is most opportune at the planning stage of a new country programme. Experience also shows that, while greater collaboration is recognized as beneficial for programmes, benefits need to be pragmatically weighed against costs in time and staff resources. Such costs will be reduced as the cycles, procedures and modes of operation of the two organizations become more harmonized.

III. HEADQUARTERS-LEVEL COLLABORATION[1]

52. Headquarters-level collaboration falls into three categories: (a) the global policy leadership provided by senior management; (b) the specific thematic or sectoral policy initiatives that are the building blocks of the global efforts; and (c) collaboration in areas where headquarters units have a special role, such as public information and evaluation. Examples of all three categories are provided below.

A. Joint letter on common goals

53. In February 1991, the Executive Heads of UNFPA and UNICEF along with those of WHO and UNDP signed a six-page joint letter on common goals, which was addressed to their staff. The joint letter emphasized the need to strengthen interagency coordination, particularly at the country level, and contained the list of common goals, which are annexed to this report. The letter stressed the need to support a number of activities, including those to enhance the administration and management of health systems; improve MCH/FP service delivery (including logistics); improve adolescent reproductive health; reduce maternal mortality; carry out situation assessments; strengthen data collection and analysis; improve the status of women; provide essential drugs (UNICEF and WHO) along with contraceptives (UNFPA); produce IEC materials; improve intervention technologies; and conduct impact assessments.

B. Latin America and Caribbean memorandum for interagency collaboration to support commitments made at the World Summit for Children

54. UNFPA and UNICEF, along with WHO/PAHO, the Inter-American Development Bank (IDB) and the United States Agency for International Development (USAID), have signed a Joint Memorandum of Understanding focusing on common efforts to address the specific needs of women, children, and adolescents in Latin America and the Caribbean, particularly in the MCH field at the country level. The Memorandum includes support for government-led coordination mechanisms, along with special efforts to support the National Plans of Action being formulated at the country level as a follow-up to the World Summit. The Memorandum then spells out measures to help promote and mobilize support for the commitments called for in the Declaration of the World Summit for Children, along with efforts to promote technical cooperation among developing countries (TCDC) and to help mobilize the necessary financial resources (nationally and internationally). The Memorandum is accompanied by a schedule of joint activities to be carried out in 1991 and 1992.

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[1] This includes also regional level collaboration.

C. Maternal and child health and family planning

55. There is notable collaboration in the areas of maternal and child health and family planning and of women's health in general at the policy and technical level at headquarters. This effort has been sustained by an ongoing WHO/UNICEF/UNFPA working group, with UNFPA serving as secretariat. The group is developing a number of joint policy statements, including one on the reproductive health of adolescents. Following an in-depth evaluation of the impact of extensive TBA training activities undertaken by all three organizations, WHO, UNICEF and UNFPA have formulated a joint policy statement on TBAs. Other joint policy statements are in progress (e.g., on MCH/FP and HIV/AIDS; breastfeeding and family planning).

56. UNFPA and UNICEF, working in close tandem with the World Bank, WHO, UNDP and others, have collaborated on various policy and programme activities in the context of follow-up to the Conference on Safe Motherhood, as well as the Conference on Better Health through Family Planning, both of which were held in Nairobi, Kenya, in 1987. For example, guidelines and various information materials have been collaboratively developed. UNFPA/UNICEF and WHO are also collaborating in the development of technical guidelines on breastfeeding, which look into factors enabling mothers to breastfeed -- such as the needed nutritional requirements, and workload and time constraints. These technical guidelines are one of the concepts forming the basis for UNICEF's "Baby Friendly Hospital Initiative", for which UNFPA collaboration is important.

57. Consultations have been held between UNICEF and UNFPA on how to strengthen collaboration in the Bamako Initiative, as well as in the essential drugs programmes. In the area of HIV/AIDS prevention, the respective focal points in UNICEF and UNFPA are in close contact and coordinate their work within the overall framework provided by the WHO/GPA. WHO, UNICEF and UNFPA have collaborated in the preparation of technical and managerial guidelines on AIDS and family planning and on AIDS and on maternal and child health. Furthermore, the preparation of an interagency joint statement on HIV/AIDS is under discussion.

D. Statistics

58. Generating country-specific statistics for use in monitoring human development is an important area of involvement for both organizations. In order to help support accelerated progress in the area of human development statistics and monitoring, an Interagency Monitoring Group has been formed, involving UNFPA and UNICEF, along with the United Nations Statistical Office (UNSO) and UNDP. Five country missions have been carried out in 1991 to assess the extent to which various countries have been able not only to generate specific data, but also to use such data to monitor human development. Individual country reports (Ecuador, Kenya, Mali, Mexico and the Philippines) have been produced, as has a global report synthesizing the findings of all five missions. It is hoped that missions to three other countries, Bangladesh, Morocco and Yemen will be completed this year.

59. In addition, both UNFPA and UNICEF are individually supporting WHO in developing information on maternal mortality, including support for further developing the maternal mortality database maintained by WHO and for producing publications, the latest of which is Maternal Mortality - A Global Factbook (September 1991). UNFPA and UNICEF intend to collaborate more actively with one another in the support each organization now provides to activities in this important area. UNICEF and UNFPA will thus step up their collaboration in the Pan Arab Project for Child Development (PAPCHILD) surveys in the Middle East and North Africa region. These surveys are directed at obtaining a broad range of population

and health-related data at the national and subnational level, and cover many mortality and health-related indicators needed for monitoring the progress made in realizing the goals set at the World Summit for Children.

60. Another area of future collaboration being pursued at the global level between UNFPA, UNICEF, UNDP and the UNSO is the modification of the National Household Survey Capability Programme. It is hoped that the Programme will assume a major role in monitoring social progress in human development. The organizations concerned will form a support group that will both serve as a forum to discuss and develop tools for monitoring, as well as to provide the substantive basis for practical technical support to countries.

E. Women

61. The role of women in development has been an important and growing area of focus for both organizations. In order to support advocacy efforts, it was felt that a publication that brought together factual information from a variety of sources into a single document would be useful. The result was an interagency collaborative effort that produced the highly successful and useful publication entitled The World's Women 1970-1990: Trends and Statistics. The analysis and subsequent publication involved the substantial collaboration and support of the United Nations Statistical Office, the Division for the Advancement of Women, UNICEF, UNFPA and UNIFEM. Both UNICEF and UNFPA see education as a priority goal as well as a key to progress in expanding the use of MCH/FP services in raising the status of women. UNICEF and UNFPA headquarters staff both participate in the Task Force of Donors to African Education, the Working Group on Female Education, and the non-governmental organization Education For All Network.

62. Considerable collaboration at the headquarters level related to women's issues is taking place in the context of the JCGP subgroup on women in development, which promotes and exchanges information related to WID and facilitates substantive collaboration, taking advantage of expertise and opportunities in each partner organization. Two major concerns of this subgroup in the recent past have been the preparation of an issues paper on Women and Structural Adjustment and the organization of the WID training seminar for senior-level field staff and government counterparts, which took place in October 1991 in Yaounde, Cameroon. UNICEF and UNFPA also collaborated with the Secretariat of the United Nations Conference on Environment and Development (UNCED) in the preparation of a symposium entitled "Women and Children First", which was held in Geneva, May 1991. The symposium examined the impact of poverty and environmental degradation on the health and welfare of women and children. It assessed their real and potential contributions to sustainable development, with a view towards UNCED Agenda 21, which will serve as a blueprint for action into the twenty-first century, to ensure sustainable development, and The Earth Charter, containing general principles and obligations on sustainable development to be adopted at the Conference.

F. Information, education and communication

63. An interagency working group of representatives of the information divisions of both UNICEF and UNFPA, together with that of WHO, is ongoing and focusing at present on developing a set of posters to convey selected joint MCH/FP messages. This working group has also prepared a travelling panel exhibit on common goals of the three organizations. Headquarters technical officers on education in both UNICEF and UNFPA are in close contact to promote field-level collaboration, in particular in the area of adolescent

reproductive health. Possibilities are also now being explored for greater use by UNFPA of social mobilization techniques developed by UNICEF.

64. There are a number of other areas in which UNICEF and UNFPA continue to collaborate at the headquarters level in support of country programmes. These include, for example, activities addressing the social dimensions of structural adjustment, environmental issues, and staff training. Many of these are also addressed and reinforced within the JCGP and its subcommittees.

IV. COLLABORATION IN A WIDER CONTEXT

65. Collaboration between UNICEF and UNFPA must be seen in a wider context in which a number of organizations -- multilateral, bilateral and non-governmental, working together with the Government -- contribute towards common goals of sustained development. Improving coordination of UNICEF and UNFPA programme activities therefore does not take place in isolation, but is rather part of a larger process initiated and led by the Government and includes other donor activities. It is therefore critical that UNICEF/UNFPA collaboration be of the sort that naturally strengthens and supports the Government's capacity to coordinate external assistance. Likewise, UNICEF and UNFPA emphasize multiparty rather than bilateral arrangements. Key partners such as WHO, the World Bank, UNDP, WFP, other multilateral and bilateral agencies and NGOs must be part of a collaborative UNICEF/UNFPA effort if such an effort is to have the fullest possible impact.

66. Strengthening collaboration between UNICEF and UNFPA occurs in a setting where a number of others make important contributions to the sectors of common concern, i.e., health, education and women in development. For example, the World Bank and bilateral donors, such as the Canadian International Development Agency (CIDA) and USAID, provide sizable financial inputs, often larger than those of UNICEF and UNFPA. At the same time, the work of UNICEF and UNFPA must be viewed together with that of WHO in assisting Governments in defining health policies and technical norms and with that of the United Nations Educational, Scientific and Cultural Organization (UNESCO) in the field of education. Likewise, collaboration between UNICEF and UNFPA, together with others, takes place within the coordination setting promoted by the United Nations Resident Coordinator. The importance that the Government attaches to coordination and the effectiveness of government coordination mechanisms, as well as of other such mechanisms, such as those of the United Nations Resident Coordinator, can promote or hinder collaboration between any two or more partners and the Government in a significant way.

67. Recently, the Administrative Committee on Co-ordination (ACC), based on the work of its Consultative Committee on Substantive Questions/Operational Activities (CCSQ/OPS), issued guidelines aimed at strengthening the functioning of the Resident Coordinator system. Many of these could have a beneficial impact on the measures spelled out in this report. For example, the Resident Coordinator is called upon to form country-level subgroups focusing on specific themes, to be chaired by the party best able to carry out this function. Similarly, the Resident Coordinator has been asked to make sure that there are regular interagency meetings focusing on substantive programme issues. It will be extremely helpful if the Resident Coordinator system can be used to help support the objectives set out in this report.

68. The large number of parties involved in the sectors in common between UNICEF and UNFPA (e.g., health, education, women) all pursue various initiatives aimed at bringing about greater coordination and complementarity of programme activities. Among United Nations operational organizations, for example,

the Joint Consultative Group on Policy (UNDP, UNICEF, UNFPA, WFP and IFAD), is making considerable headway in harmonizing programming procedures, synchronizing programming cycles, and coordinating a number of other important activities at the country as well as headquarters level. Both UNICEF and UNFPA actively participate in and promote the JCGP process.

69. Several other coordination and consultative mechanisms exist, such as the UNDP Roundtables and World Bank donor consultations. For these to be effective, all concerned parties need to participate in the consultations. For its part, UNFPA has a mandate to assist in the coordination of population-related activities within the United Nations system and at the country level whenever it is so requested by the Government. This function has been expanding as population programmes have become more complex, inputs have grown and Governments, as well as other donors, have increasingly recognized the need to further improve coordination and have called upon UNFPA to facilitate such coordination.

70. Notable progress is being made in harmonizing programming cycles. For example, UNFPA and UNICEF (along with UNDP) have sought to harmonize their cycles with that of the Government. Evidence of this can be seen in the UNFPA and UNICEF country programmes submitted this year to the Governing Council and the Executive Board. Substantive results of this alignment should be more visible in a few years' time. Exchange of information and consultation are also reportedly taking place more and more at the country level. In an increasing number of cases, coordination of programme matters is becoming more substantive and effective. However, in many countries, for a number of reasons, this stage has not yet been reached.

71. Both UNICEF and UNFPA have made several special initiatives to strengthen coordination and collaboration with a number of other partners. For example, UNFPA and the World Bank have had, and continue to have, many high-level policy exchanges, followed by programme consultations. The focus has been on specific countries where the World Bank has large-scale inputs in the population sector. Similar consultations have been conducted between UNFPA and the regional development banks. UNFPA has also put emphasis on strengthening collaboration with NGOs and continues its close cooperation with WHO, as well as with UNDP. In a similar vein, UNICEF has an extensive array of mechanisms to ensure close collaboration with WHO, including a joint committee of their governing bodies (the Joint Committee on Health Policy) and extensive inter-secretariat meetings and consultations. Likewise, with the World Bank, collaboration has been strengthened through the processes related to the follow-up of the World Conference on Education for All and to areas such as sustainable maternal and child health systems in Africa. Special attention is also paid to collaboration with NGOs, and special mechanisms exist with a number of bilateral aid agencies in areas related to MCH.

72. As the review in section II.B. above indicates, various examples of collaborative programme activities, involving several donors and organizations, can be found. For the future, there are some additional promising examples which, if well implemented, will provide a better test of collaboration. However, overall, all donors need to collaborate with Governments in a more substantive manner, assisting first in an overall assessment of needs, then helping the Governments to develop national programme frameworks for specific sectors, e.g., health. Governments and donors would then be able to fit all inputs within this framework, which, by definition, would be in keeping with the strategies, approaches and priorities defined by the Government.

V. FURTHER ACTIONS

73. This report has discussed the large degree of complementarity between the mandates of UNICEF and UNFPA. In reviewing specific information on coordination of UNICEF and UNFPA activities, a number of positive examples can be found, as is illustrated in sections II and III above. In most countries, field office staff sometimes share information about each other's programmes and consult with one another periodically. In a number of cases, collaboration includes sharing of inputs to commonly or jointly supported activities. In a few countries, this collaboration is becoming more substantive and systematic, including synchronization of programming cycles, joint or shared assessment of needs and collaborative planning of an overall strategy and truly complementary programmes. Collaboration between UNICEF and UNFPA is expanding and should be an integral and systematic part of programming. Towards this end, UNICEF and UNFPA have agreed to implement measures to further improve coordination of country programmes as well as to promote policy-level exchanges. There is considerable potential to be achieved through strengthened common efforts, and these will be made a priority for both organizations. In some cases, this will be done on a bilateral basis. In many cases, successful collaboration will need to include WHO (given its coordinating authority for international health and its technical policy-making role), the World Bank (given the size of its activities), key bilateral and NGO partners, as well as other relevant United Nations organizations.

(a) The sequencing of measures to promote collaboration is important. UNFPA/UNICEF collaboration is best strengthened through first defining common, substantive goals that are priorities of the recipient Government. These should then be supported by strengthened links in each other's programming processes. To ensure this process, the leadership of the two organizations intends to formulate policy and assess implementation in a manner that helps encourage and institutionalize such collaboration.

(b) The National Programmes of Action to guide the implementation of the commitments made during the World Summit for Children (which are being prepared by national governments) in many cases can serve as an invaluable tool for country-level efforts being supported by UNFPA and UNICEF. They should therefore be actively supported. Likewise, the two organizations will cooperate closely in undertaking activities to achieve the goals of the Amsterdam Declaration and in carrying out country preparations for the 1994 International Conference on Population and Development.

(c) Both organizations will use their programming processes in a manner that supports collaboration and common effort. As needed, UNICEF and UNFPA will review their respective programming policies and procedures with a view to identifying and removing obstacles to collaboration. Harmonization and synchronization of programming procedures will go a long way towards improving coordination.

(d) Regular consultations during each other's programming processes will begin at the earliest stages and include cross-participation in programme review and strategy development (UNFPA) and situation analysis (UNICEF). This will provide the opportunity for UNICEF and UNFPA, along with WHO and others, to determine, together with the Government, priority needs and an overall national strategy for the sector concerned, and to define national objectives with reference to global-level consensus goals, such as those of the World Summit for Children and the Amsterdam Declaration on population. It will also provide an opportunity to collaborate on the National Programmes of Action for the implementation of the commitments made during the World Summit for Children.

(e) Field offices will be instructed to make regular and systematic use of collaborative efforts and common elements throughout the programming process. This will include the sharing of basic data and information as inputs to situation analyses and programming, to monitoring and evaluation activities and cross-participation in evaluation work, as well as collaboration in programme development, with a view to maximizing complementarities. Commonly supported activities will be encouraged and expanded. Country programme documents will clearly identify complementary and collaborative activities.

(f) Maternal and child health and family planning activities represent the largest single area of common endeavour. In cooperation with WHO and others, the two organizations intend to focus on:

- cross-participation in the development of an overall MCH/FP strategy within primary health care;
- provision of complementary support for integrated services at the community level, integrating MCH/FP with other components;
- collaboration to support government efforts to train health personnel and develop health information systems and supply and logistics systems.

(g) In cooperation with UNESCO and others, UNICEF and UNFPA will strengthen collaborative efforts in the area of primary school education, non-formal education, health education and population education, as spelled out by the Conference on Education for All (Jomtien, Thailand, March 1990). There will be particular priority given to women's education/literacy and the schooling of the girl child.

(h) Common efforts by the two organizations to improve the status of women through activities aimed at providing training for women, strengthening women's organizations, creating micro-enterprises and income-generating opportunities, and improving reproductive health and promoting Safe Motherhood will be strengthened.

(i) UNICEF and UNFPA will develop common elements in their social mobilization and information/communication activities. These would address such issues of common concern as Safe Motherhood, age at marriage, education of girls, mobilization of NGOs, protection of women and children from HIV/AIDS, the Baby Friendly Hospitals Initiative (BFHI) and other efforts to promote nutrition and breastfeeding. In many cases, WHO will be closely involved, because of its special technical role, for example, vis-à-vis BFHI and HIV/AIDS.

(j) These measures will be implemented through policy directives to field and headquarters staff. To help support these directives, UNICEF and UNFPA will also be incorporating them in common and individual training and orientation seminars. Moreover, successful implementation of collaborative efforts will be an important element in assessing staff performance.

ANNEX

Common Goals for WHO, UNICEF and UNFPA[2]

The following goals for the health and development of women and children are common to WHO, UNICEF and UNFPA. These goals reflect existing policies of our Organizations. With respect to WHO and UNICEF, they have recently been reviewed by the WHO/UNICEF Joint Committee for Health Policy and expressed as the WHO/UNICEF Common Goals for the next United Nations Development Decade. The most recent expression of these goals by UNFPA is found in the Amsterdam Declaration adopted by the International Forum on Population in the Twenty-first Century (6-9 November 1989, Amsterdam).

Each of our Organizations has additional policies bearing on the health and well-being of women and children. While these additional policies may not be expressed explicitly in the policies and programmes of the other agencies, they nonetheless are usually consistent with the approaches and objectives of the other agencies and, implicitly, are complementary to our common goals. We therefore draw your attention to these other policies as well, in order that our respective staffs are familiar with them and take them into account in the planning and implementation of coordinated and complementary support to national programmes for maternal and child health and family planning.

We have included under the rubric of "Goals" statements that many would consider as "Approaches". We have done this intentionally to emphasize the point that the processes by which the goals are attained are often as important as the goals themselves, particularly if the concepts of self-reliance and sustainability in development are to be realized.

1) Between 1990 and the year 2000, reduction of maternal mortality rate by 50 per cent;

2) Between 1990 and the year 2000, reduction of infant and under-5 child mortality rates in all countries by one-third or to 50 and 70 per 1,000 live births respectively, whichever is less;

3) Access by all couples, especially women, to family planning information and services, so as to avoid pregnancies that are too early, too late, too many or too frequent during a woman's reproductive cycle;

4) Enable virtually all women to exclusively breast-feed their child for four to six months and to continue breastfeeding with complementary food well into the second year;

5) By the year 2000, universal access to and completion of primary education by at least 80 per cent of primary school aged children, and reduction of adult illiteracy rate (the appropriate age group to be determined in each country) to at least half its 1990 level, with emphasis on female literacy;

6) The most urgent priority in education is to ensure access to, and improve the quality of, education for girls and women, and to remove obstacles that hamper their active participation.

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[2] As adopted in May 1990 by WHO, UNICEF and UNFPA

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FOR ACTION

UNICEF ACTIVITIES IN CENTRAL AND EASTERN EUROPE, THE COMMONWEALTH OF INDEPENDENT STATES AND THE BALTIC STATES

SUMMARY

In response to Executive Board decisions 1990/5 (E/ICEF/1990/13) and 1991/20 (E/ICEF/1991/15), the present paper reports on UNICEF activities in Central and Eastern Europe as well as in the Commonwealth of Independent States and the Baltic States. Following a brief introduction, chapter I describes the needs of children and women. The UNICEF response to the emergency situation in the region is detailed in chapter II, while chapters III and IV report on inter-agency collaboration and links with non-governmental organizations in establishing mechanisms to deal with the situation. Chapter V describes advocacy activities carried out to promote the protection of children during the current period of economic and political transition. Proposed recommendations for Executive Board review and approval are contained in chapter VI.

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INTRODUCTION

1. Executive Board decision 1990/5 (E/ICEF/1990/13) and decision 1991/20 (E/ICEF/1991/15) requested UNICEF to undertake the following activities with regard to Central and Eastern Europe:

(a) To report on the impact on children of the changing situation in Central and Eastern Europe;

(b) To provide technical support to rethink policies for child survival, development and protection in the context of the new situation in Central and Eastern Europe;

(c) To respond, on an exceptional basis, to specific requests for support within the normal UNICEF practices.

2. The Board authorized a level of $1 million per year from the administrative and programme support budget for the period 1990-1992 to be spent in support of data collection on the situation of children and women, analytical studies, technical workshops, information materials and other related activities, including staff costs (see table 1 for details on the administrative budget). The Board further requested UNICEF to consult closely with other United Nations organizations active in Central and Eastern Europe so as to avoid unnecessary duplication.

3. UNICEF assistance to the countries of Central and Eastern Europe and the former Soviet Union has been provided within the framework of this mandate. Despite the rapidly evolving situation in the region during the past two years and the significant economic and political transformations that have taken place, this Board policy has enabled UNICEF to respond to a situation of growing and changing need, albeit on a modest scale.

4. As of mid-1992, it has become clear that many millions of children and women in these parts of the world are being adversely affected by the rapidly deteriorating circumstances, resulting in acute human need, often significant suffering and generally widespread deterioration in health, education and social protection. This is happening on a scale much more widespread than was evident or existent at the time of the Board policy discussions and decisions in 1990, or even 1991.

5. Within this policy, during the past two years UNICEF has provided emergency support on an exceptional basis to Albania, Yugoslavia, Romania and the former Soviet Union, including Chernobyl. In addition, missions have been carried out to six countries of Central and Eastern Europe (Albania, Bulgaria, Czechoslovakia, Hungary, Poland and Romania), the three Baltic States (Estonia, Latvia and Lithuania) and all 11 States comprising the Commonwealth of Independent States (CIS) (Armenia, Azerbaijan, Belarus, Kazakhstan, Kyrgyzstan, Moldova, the Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan) in order to obtain a preliminary overview of the situation of

children, and in some countries, to initiate data collection and analytical studies. Workshops and seminars have also been held aimed, inter alia, at advocating social policies to protect children and other vulnerable groups during the transition period. As a follow-up to the World Summit for Children, UNICEF is also promoting the preparation of national programmes of action. Analyses of the situation of children by local authorities, with the participation of various national groups and some UNICEF support, are being carried out in many of the countries to provide a solid basis for the programmes of action. Further details on these activities are given further on in the present paper.

I. THE NEEDS OF CHILDREN AND WOMEN

6. The process of transition to more market-oriented economies in Central and Eastern Europe and the CIS is causing a profound disequilibrium in virtually all aspects of the economy and the society. For children and other vulnerable groups it has raised a number of problems similar to those which arose in many developing countries in the 1980s. The human repercussions have often been compounded by the "shock therapy" of adjustment programmes without adequate social protection. Focusing primarily on curbing inflation, reducing the fiscal deficit and privatization, reform policies adopted by almost all the formerly socialist countries of Europe are resulting in a significant measurable decline in the welfare of the population as a whole. The greatest negative impact is borne by the most vulnerable groups - children from poor families and from large families, the unemployed, youth in search of first employment, the elderly and the homeless.

7. Despite historical, national and cultural differences among the countries moving from a centralized, authoritarian socialist system to a liberalized market economy, there are a number of common problems. These include growing unemployment (especially among women), reduction in preschool education and child care, the sharp reduction in household food supplies due to inflationary prices, reductions of child/family allowances and increasing homelessness. The sudden and drastic decline in household income, social transfers and, in some cases, social expenditures on health, education and child care are making the transition serious and painful for many children. Many countries are also experiencing extreme environmental degradation, an increasing manifestation of nationalist tensions, disregard for minority rights, increasing juvenile delinquency and growing numbers of street children.

8. The situation in the CIS and the Baltic countries has developed more recently, but there, to an ever greater extent, economic transition is accompanied by growing economic and social disruption. Over the last six months, there has been a serious undermining of existing social support systems and of the health and welfare of women, children and vulnerable groups. In a number of countries there is evidence of rising morbidity and mortality and a resurgence of infectious diseases caused by the breakdown of immunization systems. A human crisis is looming, as analysed in the reports of the recent UNICEF/World Health Organization (WHO) collaborative missions,

which also included the participation of the United Nations Population Fund (UNFPA), the World Food Programme (WFP) and the United Nations Development Programme (UNDP). The number of people affected, and how seriously, will depend greatly on the speed and relevance of the actions taken to provide timely, well-focused support, both nationally and internationally, especially in the areas of health and nutrition.

9. The UNICEF/WHO collaborative missions recommended that the international donor community provide $418 million for support to health in 1992 and 1993. Of this, $100 million of urgent support is needed immediately, and $318 million would provide priority support in 1992 and 1993. These are estimates of total requirements for international support for health and meeting urgent human needs. They are not estimates of support needed from UNICEF, WHO or from the agencies that provided staff for the missions, although these agencies might provide part of the total requirements if funding is made available. About two thirds of the support is needed for vaccines and essential drugs and the remainder for technical cooperation and support for nutrition, the promotion of breast-feeding, family planning, environment and low-cost water supply and sanitation. In addition, the reports recommended that a strong human component be added to the adjustment policies being pursued by the Governments concerned. Monitoring of the changing human situation is needed to ensure well-informed adaptations of targeted assistance. The provision of the recommended $418 million of assistance would be the most cost-effective way of rehabilitating the existing health system and assisting in its restructuring in the context of a market-oriented economy. It would be infinitely more expensive to rebuild the system if it were to collapse.

II. EMERGENCY RESPONSES

A. Romania

10. After an initial assessment by UNICEF in January 1990 of the emergency situation of children in institutions, a shipment of drugs, food and medical equipment was provided to Romania. This was followed in August 1990 by an inter-agency mission to develop a comprehensive programme of emergency assistance. In January 1991, using emergency funds donated by various Governments and National Committees for UNICEF, an office staffed by a UNICEF special representative and five local personnel was established. To date, funds totalling approximately $4 million have been received by UNICEF.

11. This enabled a wide range of activities to be initiated in 1991, and a network of relationships with both Romanian and international partners was established. In 1992, emphasis is being placed on sustaining activities such as training and monitoring, while promoting the development of appropriate policies and practices through advocacy. Experience to date shows that the investment of limited UNICEF resources can bring about a significant change for children. The Government has requested UNICEF to consider maintaining its presence for an additional two years (1993-1994). By extending its commitment

at a modest level, UNICEF could continue to help promote the well-being of Romanian women and children and also take advantage of the opportunity to learn from the Romania experience. (Further details on the emergency programme in Romania are provided in documents E/ICEF/1992/CRP.3 and Add.1.)

B. Albania

12. In June 1991, the Government of Albania requested UNDP to organize an inter-agency mission to assess the urgent humanitarian needs arising from a recent democratic election and the consequent decision to restructure economic and social policies based upon free market principles. UNICEF participated in the mission, which found a situation of economic crisis with conditions paralleling some of the world's poorer nations. Albania's per capita income is estimated at less than $600 per year.

13. In August 1991, UNICEF led a second inter-agency mission which focused specifically on identifying the critical needs of children. The mission confirmed that the health status of children was being seriously compromised; rates of unemployment were soaring; food supplies were adversely affected by drought and the disruption of distribution networks; production was stagnating due to the lack of essential raw materials; inadequate safety nets for vulnerable groups were increasing the effects of poverty; most food items were rationed; and poor and constrained public services were under strong pressures of further curtailment. In addition, primary health care facilities were almost totally lacking in basic equipment and supplies; diagnostic and therapeutic possibilities were severely limited by the acute lack of syringes and essential drugs; and hospitals were in a state of severe disrepair. The expectation was for further deterioration before the needed adjustments to a market economy were in place. In short, a chronically poor population faced increased impoverishment.

14. Based on those findings, an emergency appeal of $1 million was launched by UNICEF, of which approximately $900,000 has been received from the Governments of Germany, Norway and Sweden and the National Committees of Italy, the Netherlands and the United Kingdom of Great Britain and Northern Ireland. Emergency medical and food supplies began arriving in Tirana soon afterwards from the UNICEF warehouse at Copenhagen. A UNICEF staff member, now based at the UNDP office in Tirana, is responsible for supervising the assistance, carrying out an in-depth analysis of the condition of children in the country and advocating for special attention to children during the period of economic and social transition.

C. Yugoslavia

15. At the request of the Secretary-General of the United Nations, UNICEF, in collaboration with the Office of the United Nations High Commissioner for Refugees (UNHCR) and the International Committee of the Red Cross (ICRC), participated in November 1991 in an assessment of the more than 500,000

persons displaced by the conflict between the various republics of Yugoslavia. Based on findings of the mission, a UNHCR/UNICEF/WHO appeal for $24 million was launched. The UNICEF portion of the appeal ($5.1 million) was for the provision of emergency medical supplies, special items for young children, supplementary food, rehabilitation services, transport, primary school supplies, project support and monitoring activities. To date, contributions of nearly $4 million have been received from various Governments and National Committees. In November 1991, UNICEF established a temporary presence in Dubrovnik, Zagreb and Belgrade, with operational support from the UNICEF office at Geneva, to assist with the emergency effort. In cooperation with UNHCR, the UNICEF presence in Belgrade and Zagreb has been extended to December 1992. A situation analysis is now being carried out to describe child-related issues in each of the republics.

D. The Commonwealth of Independent States

16. Following an assessment mission of the situation at Chernobyl in June 1991, UNICEF provided iodized oil capsules and ultrasound equipment for the treatment of iodine deficiency disorders among children, with a contribution made by the German Committee for UNICEF. UNICEF also participated in the Inter-Agency Task Force on Chernobyl, under the leadership of the United Nations Centre at Vienna.

17. In December 1991, UNICEF provided $200,000 of essential drugs and medical equipment as part of the "Russian Winter Campaign" and funded by the German Committee for UNICEF. In February 1992, UNICEF provided measles vaccine to the Russian Federation to enable vaccinations to proceed despite the lack of local vaccine production, which had ceased after October 1991. An initial three-month supply of measles vaccine was also provided to 10 other CIS Republics and the Baltic States in March and April, following the UNICEF/WHO collaborative missions. Expenditures for vaccines and a small amount of essential drugs amounted to just under $700,000.

E. UNICEF expenditures in 1991 and 1992

18. UNICEF emergency support to the countries of Central and Eastern Europe and the CIS totalled $3.3 million for 1990-1991 (see table 2). Over the same period, expenditures have totalled just under $1 million for analytical work, advocacy and support staff. Expenditures in 1992 in all categories are expected to increase somewhat and, including supplementary contributions, to reach an estimated $4 million to $5 million (see table 3). This would be significantly less than 1 per cent of UNICEF total annual programme expenditure (see table 4).

III. INTER-AGENCY COLLABORATION

19. The new challenges in Central and Eastern Europe and the CIS also offer new opportunities to ensure strong inter-agency collaboration at the earliest stages, and UNICEF is strongly committed to guaranteeing such collaboration. The process has already begun, and a number of corresponding mechanisms have been established.

20. In order to assure common goals and strategies from the outset, UNICEF has undertaken some initiatives to ensure inter-agency participation in each of the critical assessment missions that started UNICEF action. Therefore, for example, WHO participated in the missions to Albania, Poland and Yugoslavia; UNHCR participated in the missions to Yugoslavia and Azerbaijan; and UNDP, WFP and the Economic Commission for Europe (ECE) participated in a joint mission to Albania. UNICEF has also participated in or provided support to other missions, such as those organized by the United Nations Centre at Vienna to assist at Chernobyl and to assess the social support system in the CIS. UNICEF is collaborating with the World Bank in a study on urban poverty and social policy in the context of adjustment. In Romania, UNICEF is working closely with the World Bank, the European Community (EC), WHO and the United States Agency for International Development (USAID) in programme development and implementation. In Albania, a UNICEF staff member is working from the UNDP premise.

21. The CIS countries have posed a special opportunity, where UNICEF expanded its collaboration and undertook cooperative missions with WHO to all but three of the CIS republics. UNDP, UNFPA and WFP also participated in these missions. In addition, at the suggestion of UNICEF, the Administrative Committee on Coordination (ACC) has formed an Inter-agency Task Force under the chairmanship of the United Nations Department of Economic and Social Development which will serve as a clearing-house and steering group for common efforts. Similar collaboration has been undertaken with the World Bank, and each organization has consulted regularly with each other's headquarters to plan mutually supportive efforts. UNICEF has helped to prepare and brief the World Bank country economic missions to the CIS and the Baltic States.

22. Plans are also under way to ensure close collaboration with UNDP and the other Joint Consultative Group on policy partners, and the Executive Director intends to use the task force established by the Administrative Committee on Coordination to ensure a holistic and collaborative approach. Any field staff would share common premises with UNDP and other United Nations system partners, as is the firm policy of UNICEF.

IV. COLLABORATION WITH NON-GOVERNMENTAL ORGANIZATIONS

23. An important dimension of UNICEF work for the children of Central and Eastern Europe has been to work with both national and international non-governmental organizations (NGOs). They are indeed very important partners for UNICEF, especially in countries where UNICEF has no country

office. In this perspective, UNICEF has supported the creation of an NGO/UNICEF Coordinating Committee in Geneva on NGO activities for children in Eastern and Central Europe. Many of the international NGOs on the Committee also have national affiliates in several countries. The work of the Committee has focused on the following: (a) exchanges of information on programmes for children implemented in the region; (b) support for the development of the voluntary sector through training and technical assistance to national NGOs; and (c) the promotion of the concept of a "first call for children" through advocacy for implementation of the Convention on the Rights of the Child. The Committee is developing a database, in collaboration with the United Nations Non-Governmental Liaison Service, to document NGO activities in the region. In Romania, UNICEF is working with NGOs on a wide range of training and capacity-building projects.

24. UNICEF has developed links with NGOs in Central and Eastern Europe to support the "baby-friendly" hospital initiative. A pilot project was initiated to assess the action needed to improve breast-feeding practices and implement the initiative in Czechoslovakia, Poland, Hungary and Germany. Short assessment missions have been undertaken and a plan of action is being prepared for each country. A training-of-trainers workshop was organized at Budapest, by the national branch of La Leche League with UNICEF support.

25. In addition, UNICEF collaborated with NGO partners in the preparation of technical workshops. A regional seminar for Central and Eastern Europe on "Juveniles in Conflict with the Law" was held in Romania in April 1992, organized by the Ministry of Justice of Romania and Defence for Children International (DCI), in collaboration with the International Association of Juvenile and Family Court Magistrates, UNICEF and the Council of Europe.

26. A regional seminar on "Implementation of the Convention on the Rights of the Child: Family-based Alternatives for Abandoned Children" will be held in Sofia, in September 1992, organized by DCI, the International Catholic Child Bureau and UNICEF Geneva, with the active collaboration of the Bulgarian National Committee for UNICEF.

V. ADVOCACY

27. Numerous advocacy activities have been carried out to promote the protection of children during the period of economic and political transition. Many have focused on the promotion of the Convention on the Rights of the Child, supported by seminars and publications.

28. Central and Eastern European countries that have ratified the Convention on the Rights of the Child now include Bulgaria (June 1991), Belarus (October 1990), Czechoslovakia (January 1991), Hungary (October 1991), Poland (June 1991), Romania (September 1990), Ukraine (August 1991), the Russian Federation, as per the ratification of the former Soviet Union (August 1990), Yugoslavia (January 1991), Lithuania (January 1992) and Albania

(February 1992). Estonia (October 1991) and Latvia (April 1992) have become States Parties to the Convention by accession.

29. The following eight States of the former Soviet Union were admitted to membership of the United Nations in March 1992, but have not yet ratified the Convention: Armenia, Azerbaijan, Kazakhstan, Kyrgyzstan, Moldova, Tajikistan, Turkmenistan and Uzbekistan.

30. All of the countries of Central and Eastern Europe have signed the Declaration of the World Summit for Children. The Russian Federation, Ukraine and Belarus have also signed. Other States of the former Soviet Union have not yet signed, as many of them have only recently become Members of the United Nations.

31. UNICEF has made contributions to several seminars on children during the transition period to assist the advocacy effort. These included "Safety Nets for Children in the Central and Eastern European Countries in Transition to the Market Economy" (Warsaw, October 1990); "Children in the Environment" (Florence, March 1991); "Child Abuse and Neglect" (Prague, June 1991); "Economic Reform, Social Transformation in Central and Eastern Europe: Focus on Children" (Florence, June 1991); "Education for Development (Budapest, October 1991); and "Qualitative Assessment Methods" (Romania, April 1991).

32. The UNICEF International Child Development Centre (Innocenti) in Florence, Italy, also published an important study entitled "Children and the Transition to the Market Economy: Safety Nets and Social Policies in Central and Eastern Europe". This publication includes case-studies of the changing situation in Bulgaria, Czechoslovakia, Hungary and Poland, as well as chapters drawing lessons and conclusions for action.

VI. PROPOSED RECOMMENDATIONS FOR FUTURE UNICEF POLICY

33. Given the primary responsibility of UNICEF to address the needs of children in developing countries, the response to the transitional needs of children in Central and Eastern Europe and the CIS will be, of necessity, limited. Nevertheless, the conditions of children and their families are clearly under threat in all of these countries, and a significant opportunity exists for UNICEF to implement low-cost strategic actions for improving their health and well-being. The particular circumstances of the transition enable UNICEF, with a modest investment of resources, to help define and establish policies and structures that will affect the basic situation of children and women for many years to come.

34. This opportunity for UNICEF to act is likely to be as brief as it is critical for the well-being of vulnerable groups. At present, social and economic reorganization is proceeding, constitutions are being rewritten and legislation is being enacted. UNICEF has the opportunity to help to ensure that the principles enunciated at the World Summit for Children and the

provisions of the Convention on the Rights of the Child become part and parcel of the fabric of the new societies. Failure to respond to this opportunity, on the other hand, will have far-reaching consequences not only for the populations of the region, but also for the people of many other countries in an interdependent world.

35. Technical assistance for the formulation of new social policies benefiting children is urgently needed. Based on experiences in other developing countries, UNICEF can help to promote low-cost approaches in the areas of health, nutrition, early child education and other sectors. In these efforts, UNICEF can play an important part, working closely with other organizations of the United Nations to assure the maximum benefit from the limited resources available. UNICEF can also play a catalytic role in facilitating the work of NGOs, particularly national NGOs, which are beginning to respond to the needs of children.

36. Most of the Central and Eastern European and CIS countries have been isolated from developments in many fields, including medical and pharmaceutical practices, education and environmental protection. Personnel have not been exposed to modern management practices and only have limited knowledge of low-cost techniques for improving health. Both practitioners and policy-makers are eager for access to international experiences and contacts, information exchange and short-term technical assistance to help them modernize their societies and further develop services for children and women. Since there is an available infrastructure and significant human as well as natural resources, and since the current crisis is largely the result of rapid unexpected economic turmoil, the prospects are good that assistance requirements will be limited to the short to medium term (one to five years). Moreover, many of the Central and Eastern European and CIS countries can be expected to join or rejoin the ranks of donor countries and thus make significant contributions to other countries that require assistance.

A. Options for UNICEF support

37. The critical issues for the future of UNICEF action in the Central and Eastern European and CIS countries relate to the focus and scale of the response. There are two areas of action in which major options exist for a change of focus and scale: support for advocacy and policy studies; and support for programme actions, including the provision of supplies. As requested by the Executive Board, a number of options are considered below, with an estimate of their budgetary implications (see also the figure at the end of the present report). Providing advocacy and policy support for all of the Central and Eastern European and CIS countries is considered. The provision of programme support is considered separately for countries that qualify, using current UNICEF criteria, for UNICEF general resources support and for those countries which would not normally qualify. In each case, the recommendation of the Executive Director is also noted.

Support for advocacy and policy studies in all the countries of Central and Eastern Europe and the Commonwealth of Independent States

Option A: Maintain present scope and scale of support for policy, analytical and advocacy work

38. Under the current mandate, support for policy development and advocacy focuses on the pursuit of the goals of the World Summit for Children and the Convention on the Rights of the Child.

39. If the current scope and scale are to be maintained, a limited increase of funding above the current $1 million provided per annum is desirable in order to allow work in the increasing number of countries now included in the CIS and Central and Eastern Europe. The number of countries under consideration has, in fact, increased about three times from two years ago.

40. Thus, a doubling of the general resources provision to $2 million per annum for support for advocacy and social policy development appears to be both reasonable and responsible. The allocation could be provided from programme funds under a regional programme covering Central and Eastern European and CIS countries.

41. The budgetary implications are as follows: $2 million per year for 1993 and 1994 and an additional $1 million for 1992 over and above the $1 million allocated in 1990; and two additional international Professional project posts and two General Service posts. The staff would be based at the Geneva office, with New York headquarters staffed by the two international Professional core staff and two General Service staff already covered under the original Board decision.

Option B: Expand the focus and scale of advocacy and policy studies

42. The focus of UNICEF work in Central and Eastern Europe and CIS countries could be broadened and the scale enlarged. The needs are vast. Opportunities to influence new societies to maintain and build upon their systems for the social protection of women and children are great.

43. The recent missions to the countries confirm that additional support, especially technical assistance in the area of social policy development, is requested and could be readily and profitably absorbed. Since the countries of the CIS have been cut off from developments in most areas and have little practice in accessing world-wide experience, there is an urgent need for international contacts.

44. If assistance of this type on an augmented scale were provided to each of the 15 countries of the former Soviet Union and to the 7 Central and Eastern European countries, a tripling or quadrupling of the current level of support for policy development could, in principle, be considered reasonable.

45. The budgetary implications are as follows: a minimum of $4 million in general resources expenditures per year; and a minimum of six additional, international Professional project staff at New York and Geneva, and four General Service Staff.

Recommendation of the Executive Director

46. The Executive Director recommends option A, the maintenance of the current scale and scope of support, adjusting it only to accommodate the increase in the number of countries. While support for advocacy and analytical and policy studies in these countries could, in principle, be profitably expanded, in view of the overarching concern of UNICEF to maintain maximum resources for developing countries, the current scale and emphasis appear justifiable.

Support for programme action

47. As far as the provision of direct programme support (as opposed to policy and advocacy support) is concerned, the countries of Central and Eastern Europe and the CIS can be divided into two main groups. The first group consists of countries that would normally qualify as recipients of UNICEF assistance using existing criteria (gross national product (GNP) per capita, child population and under-five mortality). At the present time, these countries include Albania, Armenia, Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan. The second group are those countries that do not meet current UNICEF criteria for assistance. The question of programme support needs to be considered separately for each group.

"Qualifying" countries

48. There are two main options: one is to make allocations from general resources and the second is to seek supplementary funds for these countries.

49. Option C: Provide support from general resources. Based on 1989 World Bank data on GNP per capita (as used by UNDP for its recent calculations) and United Nations Statistical Office data on child population and under-five mortality, the eight countries in this group would qualify for a minimum allocation of $750,000 per year.

50. A programme recommendation would be prepared for each country and submitted to the Executive Board for approval in 1993. Normal UNICEF guidelines would also allow for the provision of additional elements of support through supplementary funds.

51. It should be noted that the recent rapid and frequent fluctuations in official GNP figures in these countries could alter estimated allocation levels and could also change the countries which are eligible.

52. The budgetary implications are as follows: a total of $6 million of general resources support for the eight countries, plus support staff (a

minimum of two international project posts, three national Professional posts and three General Service posts based in a common United Nations office in one of the CIS countries, probably in one of the republics of Central Asia or Kazakhstan).

53. Option D: Provide support from supplementary funds. Because of the difficulty in assessing GNP per capita, given monetary fluctuations and definitional differences, and the rapidly changing needs for assistance in this group of Central and Eastern European and CIS countries, a more flexible approach to funding needs may be preferable to the application of the standard formula. The use of supplementary funds would permit a rapid response to children's needs as they emerge. Such country programmes would take as a rough guideline the UNICEF minimum level of $750,000, but as with normal UNICEF guidelines would allow for the preparation of some element of additional support also using supplementary funds. For each of the countries, a country programme recommendation would be prepared and submitted to the Executive Board in 1993.

54. The budgetary implications are as follows: approximately $6 million in supplementary funds, plus supporting staff, and two international project posts, three national Professional project posts and two General Service project posts based in a common United Nations office in one of the CIS countries, probably in one of the republics of Central Asia or Kazakhstan.

Recommendation of the Executive Director

55. At present, the Executive Director recommends option D for the countries of Central and Eastern Europe and the CIS which would normally qualify as recipient countries. Thus, support would be provided from supplementary funds using current UNICEF programme priorities and the findings of recent missions as guidelines for focus, broad content and level. Programming would be the responsibility of a small group based in one of the CIS countries of Central Asia or Kazakhstan, Geneva and New York.

"Non-qualifying" countries

56. The unusual circumstances of the transition, with its attendant hardships and opportunities, could provide the justification for a limited response by UNICEF in countries which, because of their level of development, would not normally qualify for UNICEF assistance. Such assistance would focus on selective but strategic interventions to influence the process of change and to respond to emergencies.

57. Option E: Provide support on an exceptional basis. This option proposes that support should only be provided on an exceptional basis, particularly in response to emergency needs as they emerge. In considering this option, it is important to bear in mind that recent experience in Romania demonstrates that selective support may also be required for rehabilitation and the development of policies that aim to improve the overall context and to prevent a recurrence of the emergency.

58. While it is obviously difficult to anticipate emergency needs, some experience has been gained in 1990 and 1991 in the Central and Eastern European countries. Extrapolating to take into consideration the likely needs of CIS countries, supplementary funds in the range of $5 million to $10 million per year might be required for the provision of such support.

59. The budgetary implications are as follows: a minimum of $5 million per year from supplementary funds.

60. Option F: Expanded material support. The sudden disruption of trade channels and the breakdown of the economic linkages between Central and Eastern European and CIS countries have resulted in major and often life-threatening shortages of medical supplies, essential drugs and vaccines. UNICEF could provide material support to help respond to this crisis until new patterns of trade and local manufacturing capacities are established. UNICEF could utilize supplementary funding through its Supply Division and warehouse facilities for the procurement of selected commodities. Such needs are particularly pressing in CIS countries. The UNICEF/WHO missions to the CIS identified urgent needs for pharmaceuticals, vaccines and medical equipment in the amount of $255 million. If UNICEF assumed responsibility for 10 per cent of this estimated amount, $25 million from supplementary funds would be required each year. A stand-alone supplementary funding submission would be made to the Executive Board in 1993.

61. The budgetary implications are as follows: a minimum level of about $25 million per year financed by supplementary funds.

62. Option G: Programme assistance related to achievement of the goals of the World Summit for Children. UNICEF support might be provided for the implementation of national programmes of action developed in these countries to achieve the World Summit goals. A range of technical and material assistance, particularly related to the use of low-cost health technologies and health promotion and financed from supplementary funds, would be provided under this option. Levels of support would vary according to population size: the 12 countries with a population under 10 million would receive an average of $500,000 per country; the 9 countries with populations of 10 million to 60 million would receive an average of $750,000; and the Russian Federation, with a population of 150 million, would receive $1,500,000. On this basis, a level of support of about $14.3 million from supplementary funding would be required.

63. The budgetary implications are as follows: $14.3 million and additional project staff financed by supplementary funds.

Recommendation of the Executive Director

64. The Executive Director recommends option E, the provision of support only on an exceptional basis, especially in response to emergency needs and in line with normal UNICEF practices.

B. Recommendations

65. If the above recommendations are accepted in principle, the following specific decisions would be needed in order to put them into effect.

Decision 1

66. In all Central and Eastern European and CIS countries, the Executive Director should be authorized to continue a programme of support consisting of advocacy, policy support and analytical work focused on:

(a) Support for the development of child-focused policies in the context of the move to market economies;

(b) Support for the development of low-cost policies for health, nutrition, water supply, sanitation and basic education, which draw on UNICEF experience in other parts of the world;

(c) Support for the preparation of situation analyses of children and national programmes of action as guidelines for the above.

67. This support would be provided through technical assistance and information exchange, including the organization of workshops, study visits, etc. Where possible and appropriate, these should be provided in collaboration with the United Nations and other agencies.

68. An amount of $2 million per year from general resources should be provided from programme funds under a regional allocation for Central and Eastern European/CIS countries instead of the current arrangement under which $1 million is provided from the administrative budget. Therefore, the Executive Director recommends that the Executive Board approve for the period 1992 to 1994 an amount of $5 million ($1 million additional for 1992 and $2 million per year for 1993 and 1994) from general resources for advocacy and policy work in all Central and Eastern European and CIS countries.

Decision 2

69. In the context of support to Central and Eastern European and CIS countries, the Executive Director should be authorized to increase the existing level of administrative support through the addition to the UNICEF office at Geneva of two international Professional and two General Service posts, funded from general resources. The posts will be used to ensure appropriate monitoring, administration and coordination of UNICEF activities in those countries. The two international posts and two General Service posts that are financed by provisions from the administrative and programme support budget, in accordance with Board decision 1990/5, should be used in New York and for similar purposes.

70. With regard to field locations, experience has shown that, in a few cases, the posting of an international staff member funded from supplementary

funds may be necessary to ensure monitoring and creative policy interaction. At present, this is the case in Romania (since January 1991), Yugoslavia (since November 1991) and Albania (since March 1992). The provision of exceptional support in other countries may require other such assignments in a few cases. In those places, field positions would be project posts funded from supplementary funds. The uncertainty of the situation and likely short-term nature of assistance would make the establishment of core posts inappropriate. UNICEF is strongly committed to locating any staff, wherever possible, in a general United Nations office, according to policies on common premises already agreed upon by the Board. Consultations are already under way with UNDP in this regard.

Decision 3

71. In addition to the above, the Executive Director should be authorized to provide, on an exceptional basis and in response to specific requests, programme support for children and women in vulnerable situations, using supplementary funding provided from special contributions using normal UNICEF procedures. UNICEF would accept such contributions on the understanding that donors would not reduce their ongoing contributions to UNICEF for work in developing countries.

72. In addition to exceptional expenditures on this basis, the Executive Director should be authorized to encourage other organizations and agencies to respond to the urgent needs of children in Central and Eastern European and CIS countries. To avoid a diversion of resources, UNICEF should advocate particularly for the deployment in the interests of children resources previously committed to military purposes. In order to facilitate the operations of other agencies, UNICEF procurement services may be used for the provision of essential drugs and other urgently needed supplies.

Decision 4

73. In each of the Central and Eastern European and CIS countries that meets UNICEF criteria for support, the Executive Director should be authorized to establish a programme financed by supplementary funds. Typically, these programmes would be of three years' duration, based on the normal minimum annual planning level of $750,000.

74. Such programmes would be based on recommendations to be prepared and presented to the Executive Board. Pending examination of these recommendations, and taking into account the acute and continuing needs identified by the UNICEF/WHO collaborative missions carried out in February 1992, emergency funds may be deployed to respond to short-term critical needs as they arise.

Decision 5

75. In the countries of Central and Eastern Europe and the CIS that would normally not be eligible for UNICEF programme cooperation, the Executive Director should be authorized, on an exceptional basis, to provide limited assistance to meet the most urgent needs of women and children through funds that might be made available in response to a special emergency appeal in line with normal UNICEF practice. The Executive Director should also be authorized to make available the services of the UNICEF warehouse at Copenhagen for reimbursable procurement of essential supplies and equipment to meet the urgent needs of women and children during the difficult transition period of the next two to three years.

Table 1. Administrative and programme support budget
(In United States dollars)

Executive Board decision 1990/5 covering 1990-1992	3,000,000
Less:	
Actual expenditures as of 31 December 1991	869,862
Unspent balance as of 1 January 1992	2,130,138
Less:	
Obligations as of 30 April 1992	1,500,000
Estimated balance available as of 30 April 1992	630,138

Table 2. Emergency support to Central and Eastern Europe and the Commonwealth of Independent States as of 31 December 1991
(In United States dollars)

Country	Allotment	Expenditure	Balance
Albania	908,915	281,915	627,000
Bulgaria	50,000	2,048	47,952
Romania	4,185,700	2,690,035	1,495,665
Yugoslavia	1,337,985	0	1,337,985
CIS	336,570	293,097	43,473
Total	6,819,170	3,267,095	3,552,075

Table 3. Estimated status of emergency funds as of 30 April 1992
(In United States dollars)

Unspent balance, 31 December 1991		3,552,075
Funds received, 1 January–30 April 1992		
Yugoslavia	2,955,386	
CIS	1,036,577	
Romania	75,067	
		4,067,030
Total		7,619,105
Less:		
Estimated expenditures, 1 January–30 April 1992		1,776,087
Estimated balance available, 30 April 1992		5,843,018

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Table 4. Emergency Expenditures in Central and Eastern Europe and the Commonwealth of Independent States in relation to total global programme expenditures
(In millions of United States dollars)

Region	1990-1991	Percentage
Asia	399.5	34.0
Africa	390.2	33.2
Americas and the Caribbean	104.4	8.9
Middle East and North Africa	134.6	11.4
Interregional	143.4	12.2
Central and Eastern Europe and CIS	3.3	0.3
Total	1,175.4	100.0

Figure
OPTIONS FOR UNICEF SUPPORT

Type of country	I Advocacy/policy analytic support		II Programme support		
	Options		Options		
Qualifying for general resources support	A* Maintain present scale and scope of support for policy, analytical and advocacy work. Budgetary implications: $2 million per year from general resources.	B Expand the focus and scale. Budgetary implications: $4 million per year from general resources.	C Provide support on the same basis as to other developing countries from general resources. Budgetary implications: $6 million from general resources.	D* Provide support from supplementary funds. Budgetary implications: Approximately $6 million from supplementary funds.	
Not qualifying for general resources support			E* Provide support only on exceptional basis, especially in response to emergency needs, and within normal UNICEF practices. Budgetary implications: $5 million to $10 million per year from supplementary funds.	F Expanded material support. Budgetary implications: $25 million per year.	G Expanded programme assistance focused on the goals of the World Summit for Children. Budgetary implications: $14.3 million from supplementary funds.

* Recommendation of the Executive Director.